

Arthur S. Krawiec

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Continued from previous page

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5084

## CERTIFICATE OF DEATH

65974

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN b. <b>4 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1668 Bruce Court</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Irvin</b> Middle <b>Addison</b> Last <b>Addison</b>		<b>4. DATE OF DEATH</b> Month <b>5</b> Day <b>7</b> Year <b>19 61</b>	
<b>5. SEX</b> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> <b>6. COLOR OR RACE</b> Male <b>Negro</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		<b>9. AGE</b> (In years last birthday) <b>54</b> IF UNDER 1 YEAR: Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min. <b>54</b> IF UNDER 24 HRS.: Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min. <b>54</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Unknown</b>		<b>11. BIRTHPLACE</b> (Country & State, or foreign country) <b>Unknown - md</b>	
<b>13. FATHER'S NAME</b> <b>Jim Addison</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary J.</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> <b>Hospital Records</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> (b) <b>Generalized Carcinomatosis</b> (c) <b>Cancer of Stomach</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19 61</b> Hour e.m. <b>11</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> While not at work <input checked="" type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from 3/29 1961 to 5/7 1961, that (I) (we) last saw the deceased alive on 5/7 1961, and that death occurred at 11:45 M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Hildegard Heard Reissman</b>		<b>22b. DATE SIGNED</b> <b>5/8/61</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Hildegard Heard Reissman, M.D.</b>		<b>22d. ADDRESS</b> <b>Crownsville State Hospital, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>5-11-61</b>		<b>23b. DATE THEREOF</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Ignace</b>		<b>23d. LOCATION</b> (City, town or county) (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>George S. Wilson 13487 Calhoun St</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 10 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Frank</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complanly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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September 2, 1900

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To the

President of the United States

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5085  
CERTIFICATE OF DEATH

05075

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2207 Druid Hill Ave.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 2mo. 4 days				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital							
3. NAME OF DECEASED (Type or print) First Middle Last Dora Anderson				4. DATE OF DEATH Month Day Year 5 20 19 61			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 25, 1897	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				11. BIRTHPLACE (County & State, or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Tom Anderson				14. MOTHER'S MAIDEN NAME Juddey ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 215-32-0705			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Cardio-respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Chronic Brain Syndrome Associated with Cardiovascular Disorder							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 3/16 19 61 to 5/20 19 61, that (I) (we) last saw the deceased alive on 5/20 19 61, and that death occurred at 4:07A. M, from the causes and on the date stated above.							
22a. SIGNATURE L. Benedict, M. D.							
22b. DATE SIGNED 5/22/61							
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.							
22d. ADDRESS Crownsville State Hospital, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-25-61							
23b. DATE THEREOF							
23c. NAME OF CEMETERY OR CREMATORY Mt Auburn							
23d. LOCATION (City, town or county) (State) md							
24. FUNERAL DIRECTOR'S SIGNATURE George P. Nelson 1348 N. Calhoun St							
25a. REC'D BY REGISTRAR DATE MAY 24 '61							
25b. REGISTRAR'S SIGNATURE Curtis L. Hines							

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5086

CERTIFICATE OF DEATH

Item 19 Film 0288 6/19/61 mh

05076

1. PLACE OF DEATH a. COUNTY <u>Cranesville State</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cranesville, Md</u> c. LENGTH OF STAY IN lb <u>518 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cranesville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>141 West St Annapolis</u> b. COUNTY <u>Annapolis</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>Cranesville, Maryland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hattie</u> First <u>Baden</u> Middle Last		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-1883</u> 77 yrs.
9. AGE (In years last birthday) <u>77</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>	11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Reed</u>		14. MOTHER'S MAIDEN NAME <u>Sedonna Reed Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>None</u>		Address <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>None</u> DUE TO <u>None</u> (a), stating the underlying cause last. (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden (5 min)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
21c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		21f. (City or town) <u>Annapolis</u> (County) <u>Md</u> (State) <u>Md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>4-19-1960</u> to <u>5-20-1960</u> , that (I) (we) last saw the deceased alive on <u>5-20-1960</u> , and that death occurred at <u>12:58 P</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict M.D.</u>		22b. DATE SIGNED <u>5-20-1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		22d. ADDRESS <u>Cranesville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-24-1961</u>		23b. DATE THEREOF <u>5-24-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewerhill</u>		23d. LOCATION (City, town or county) <u>Annapolis</u> (State) <u>Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. III</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Fuma</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Fuma</u>		25c. DATE <u>MAY 23 '61</u>	

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Chapman III 15 Nov 1940



## BALTIMORE STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

5087

## CERTIFICATE OF DEATH

Reg. Dist. No.

65077

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARIA</b> Middle <b>BALDWIN</b> Last		4. DATE OF DEATH Month <b>MAY</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1869</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles W. Baldwin</b>		14. MOTHER'S MAIDEN NAME <b>Annie Hopkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Mr. Fletcher S. Joyce-</b>		Address <b>Millersville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>S.C.U.D. (Sclerotic Cardio Vascular Disease)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Right Heart Failure</b> (c) <b>Right Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>484</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August, 1959</b> to <b>May 25, 1961</b> , that I last saw the deceased alive on <b>5-25-61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Felix L. Lueck</b>		ADDRESS (Street, city or town, state) <b>P.O. Box 97</b>	
PHYSICIAN'S NAME (Type) <b>Febus G. Mowbray</b>		DATE SIGNED <b>5-26-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baldwin Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Millersville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		24a. RECEIVED BY REGISTRAR <b>MAY 29 61</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Robert S. Hanks</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Arthur L. Kinn

VR A15 (4)  
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TO HO: **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

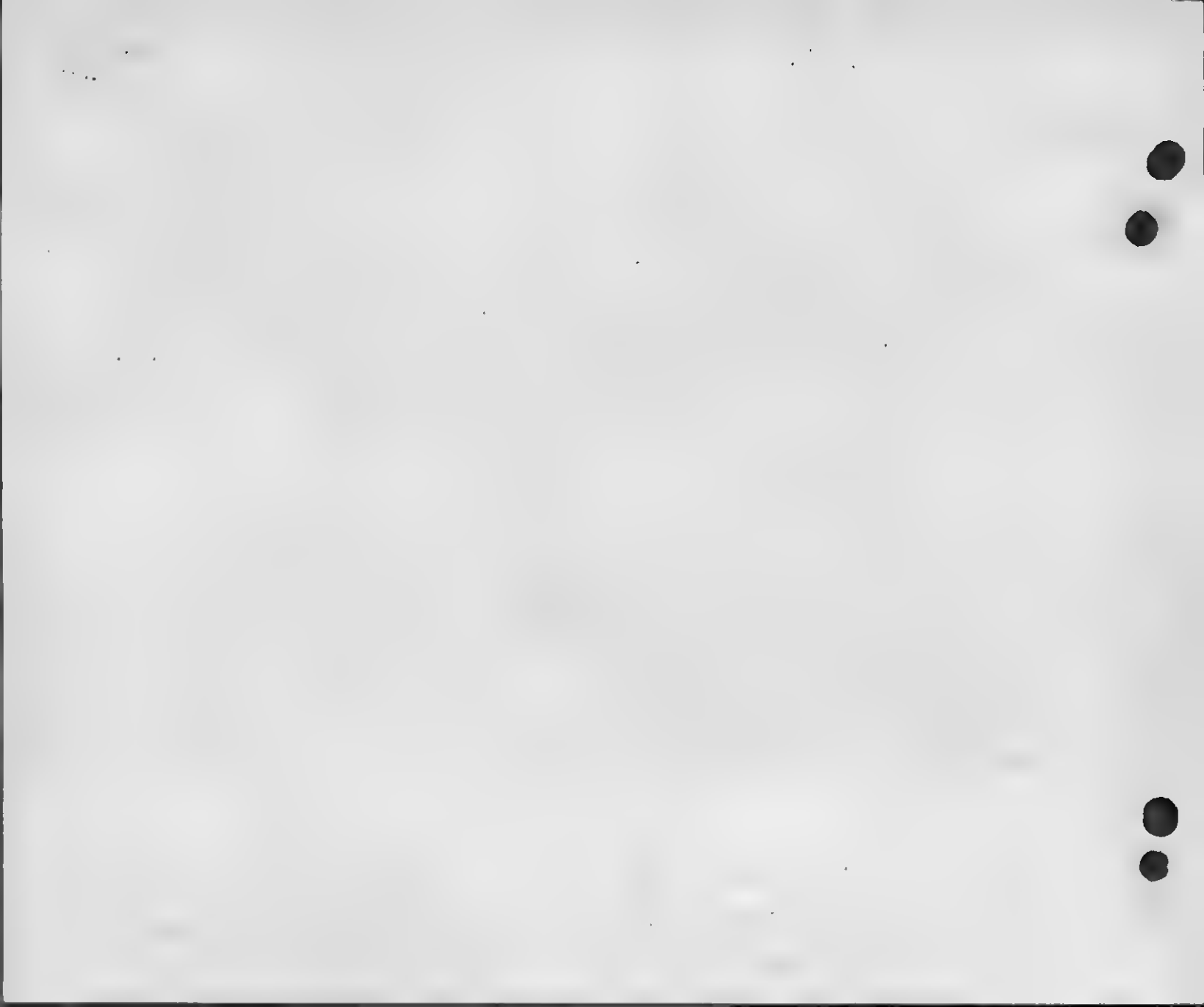
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5089

65079

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived prior to death) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General</u>				d. STREET ADDRESS <u>Lothian</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma H. Brady</u>				4. DATE OF DEATH Month Day Year <u>May 27 1961</u>			
5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 31, 1889</u>				9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Days <u>19</u> Hrs. <u>61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
11. FATHER'S NAME <u>JOHN TAYLOR</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. MOTHER'S MAIDEN NAME <u>SARAH MARSHALL</u>				14. SOCIAL SECURITY NO. <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INTERVIEWER'S NAME <u>Hospital records</u>				18. ADDRESS <u>Lothian, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO (b) <u>coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause: <u>none</u> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH: <u>none</u> RELATED TO THE TERMINAL DISEASE: <u>none</u> CONDITION OF VENTILATOR: <u>none</u> INTERVAL BETWEEN ONSET AND DEATH: <u>none</u>							
MEDICAL CERTIFICATION 20a. ACIDENT WAS CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature or injury. Part I of item 18) 20c. TIME OF INJURY: Month Day Year. Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY: home, factory, street, office bldg., etc.) 20f. City or town: <u>Lothian</u> 21. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1961</u> to <u>May 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 26, 1961</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above. 22. SIGNATURE <u>Emily H. Wilson</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Emily Wilson</u> 22d. ADDRESS <u>Lothian, Maryland</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>MAY 29, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cemetery</u> 23d. LOCATION (City, town, county) <u>Lothian, Maryland</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> 25. REC'D BY REGISTRAR <u>Lothian, Maryland</u> 25b. DATE <u>MAY 31 '61</u>							





## 65981

PLACE OF DEATH a COUNTY		ANNE ARUNDEL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE		Maryland		b COUNTY		Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Ft Geo G. Meade		4 Years		U.S. Army Hospital, Ft Geo G. Meade, Md		Odenton		301 Queen Ann Avenue					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day Year	
JOHN		T.		BRITTAIN				May		15		19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS	
MALE		Cau		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		14 January 1921		40 yrs		Months		Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Signal Officer		Army		Indiana		USA							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME									
Theodore M. Brittain				Stella Teague									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no not known)		16. SOCIAL SECURITY NO		17. INFORMANT		Address							
Yes		311-18-6058		Mrs. Mary E. Brittain, (wife)		301 Queen Ann Ave, Odenton, Maryland							
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c)]													
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction													
7-61 DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO													
(c)													
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I													
19. WA. AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
				Hour a. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
				19									
21. I certify that (I) (this happens to) attended the deceased from 6:45pm 15 May 1961 to 7:00pm 15 May 1961 that (I) (we, last saw the deceased alive on May 15 1961 and that death occurred at 7PM, from the causes and on the date stated above													
22a. SIGNATURE		22b. PHYSICIAN'S NAME (Type)		22c. DATE SIGNED		22d. ADDRESS		22e. MED. DIRECTOR <input type="checkbox"/>		22f. STAFF PHYS. <input type="checkbox"/>		22g. DATE SIGNED	
Stanley Siegelman		Stanley Siegelman, Captain, MC		15 May 1961		U.S. Army Hospital, Ft Geo G. Meade, Md							
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)							
Burial		19th May 1960		Arlington National Cem.		Arlington, Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Richard V. [Signature]		Glen Burnie, Md.		DATE MAY 19 61		Arthur S. [Signature]							



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9,60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5091 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 65081

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>Crownsville State Hospital</u>	
3. NAME OF DECEASED (Type or print) <u>Harry</u>		4. DATE OF DEATH <u>May 3, 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1894</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. AGE (In years last birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delivery</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jas. Holliday</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Britton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-18-4712A</u>	
17. INFORMANT <u>Wm. Britton</u>		Address <u>120 E. Chesapeake Ave. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease.</u> (b) <u>Exposure.</u> (c) <u>Due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/11/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stephenson</u>		22d. LOCATION (City, town, or country) (State) <u>Sparks, Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR <u>Wm. S. Britton, Jr.</u>		24a. REC'D BY REGISTRAR <u>May 11 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur P. ...</u>		24c. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5092

## CERTIFICATE OF DEATH

65082

1. PLACE OF DEATH  
a. COUNTY MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville  
c. LENGTH OF STAY (in days) 2 years 11 mos. 10 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution)  
a. STATE Maryland  
b. COUNTY Harford  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forest Hill  
d. STREET ADDRESS Unknown

3. NAME OF DECEASED (Type or print)  
First Janie Middle Gordon Last Britton

4. DATE OF DEATH  
Month 5 Day 23 Year 1961

5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH August 26, 1874  
9. AGE (in years) 86 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (City, town, or foreign country) Maryland  
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gordon 14. MOTHER'S MAIDEN NAME Lavinia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Hospital records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Bronchopneumonia  
DUE TO 450.0  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
DUE TO Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND CONDITION GIVEN IN PART I.  
19. None 20. None

20c. TIME OF INJURY Month 5 Day 23 Year 1961  
Hour a.m. 2:58 p.m. 19

20d. INJURY OCCURRED at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) at work

21. I certify that (I) (this hospital) attended the deceased from 6/13, 1958, to 5/23, 1961, that (I) (we) last saw the deceased alive on 5/23, 1961, and that death occurred at 2:58 AM, from the causes and on the date stated above.

22a. SIGNATURE L. Benedict, M. D. 22b. DATE SIGNED 5/23/61

22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D. 22d. ADDRESS Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/26/61  
23c. NAME OF CEMETERY OR CREMATORY West Liberty 23d. LOCATION (City, town or county) Forest Hill  
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Turtz ADDRESS Jarrettsville, Md 25a. REC'D BY REGISTRAR William S. Howard 25b. REGISTRAR'S SIGNATURE William S. Howard DATE MAY 26 '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

655

05083

### 1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

### 2. USUAL RESIDENCE (When deceased lived in institution)

a. STATE

Maryland

b. COUNTY

Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel Gen. Hosp.

d. STREET ADDRESS

Box 269, Rt. 1, Sherwood Forest

### 3. NAME OF DECEASED (Type or print)

William H

BROWN

5. SEX

Male

Colored

7. MARRIED ☐ NEVER MARRIED ☒

8. DATE OF BIRTH

8-17-1902

9. AGE (In years IF UNDER 1 YEAR IF UNDER 2 YEARS)

58 yrs. 19 19 19 19

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

trackman

10b. KIND OF BUSINESS OR INDUSTRY

railroad

11. BIRTH PLACE (County & State or foreign country)

Anne Arundel, Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A

### 13. FATHER'S NAME

Charles Brown

### 14. MOTHER'S MAIDEN NAME

Martha Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give number of service)

no

16. SOCIAL SECURITY NO.

218-07-3105

17. INFORMANT

Martha Butler Brown Rt. 1 Sherwood Forest

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUPLICATE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUPLICATE

Post-operative fluid & electrolyte loss 5 days

diffuse abdominal visceral metastasis 3 wks.

Carcinoma, probably primary in pancreas 12 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

Subtotal gastrectomy for gastric ulcer benign, 1955

20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY (Hour, day, month, year)

19

20d. INJURY OCCURRED (While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from May 13, 1961 to May 19, 1961, that (I) (we) last saw the deceased alive on May 19, 1961, and that death occurred at 9:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Merton T. Waite, M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

5-19-61

22c. PHYSICIAN'S NAME (Type)

Merton T. Waite, M.D.

22d. ADDRESS

121 Cathedral St. Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

5-23-61

23c. NAME OF CEMETERY OR CREMATORY

Fowlers

23d. LOCATION (City, town or county)

Anne Arundel

24. FUNERAL DIRECTOR'S SIGNATURE

C. E. Hulse

ADDRESS

Annapolis, Md

25a. REC'D BY REGISTRAR

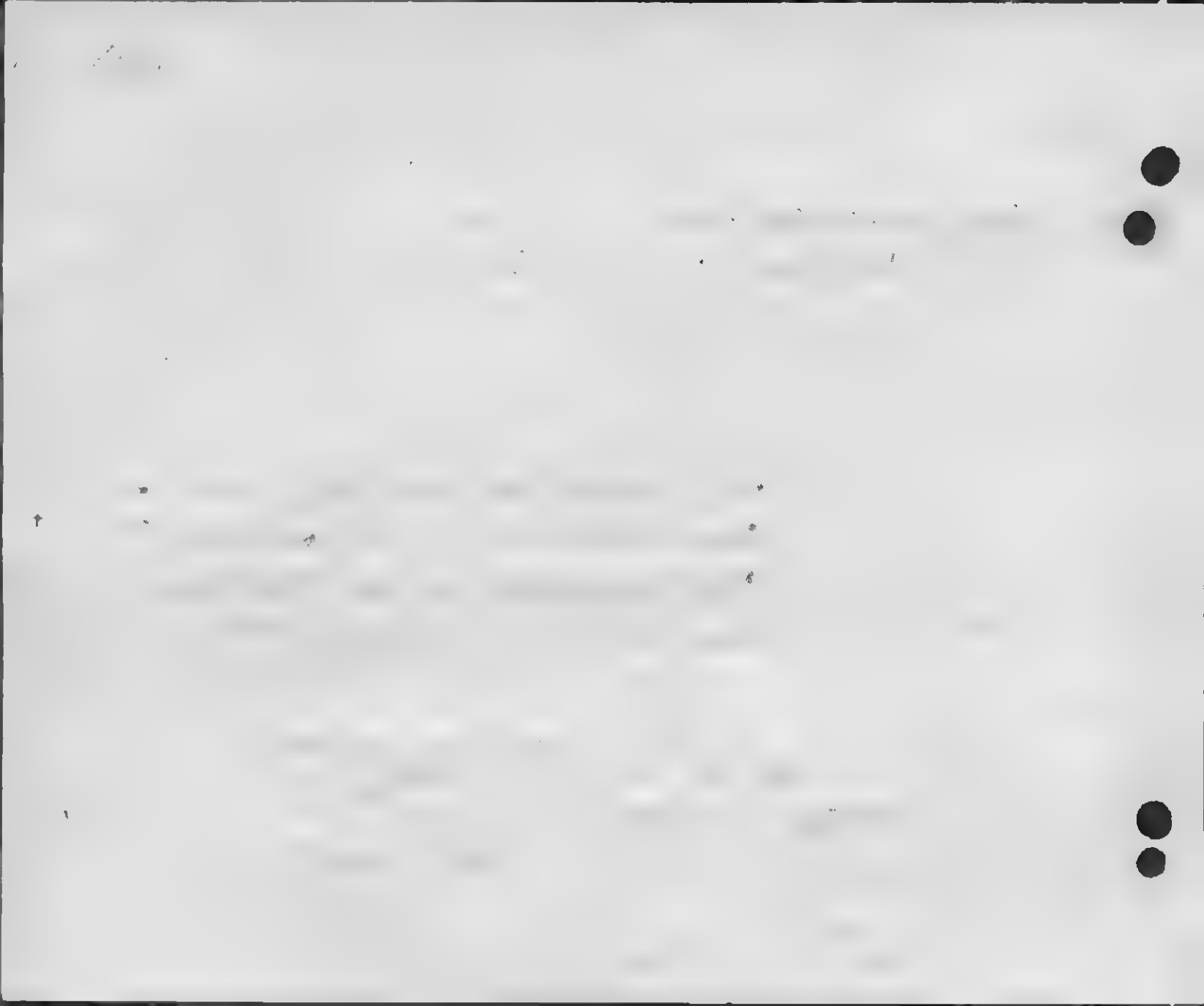
25b. REGISTRAR'S SIGNATURE

DATE MAY 23 '61

C. E. Hulse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO DE. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, the Medical Director, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. NO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH  
a. COUNTY Anne Arundel  
b. CITY OR TOWN if outside corporate limits write RURAL and give nearest town Fort George G. Meade  
c. LENGTH OF STAY IN b MARYLAND  
d. NAME OF HOSPITAL OR INSTITUTION if not in hospital give street address United States Army Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, give name)  
a. STATE District of Columbia  
b. COUNTY  
c. CITY OR TOWN if outside corporate limits write RURAL Washington  
d. STREET ADDRESS 1301 Vermont Ave. NW

3. NAME OF DECEASED (Type or print) MARTIN EDWARD BYBUTH  
4. DATE OF DEATH MAY 25 19 61

5. SEX Male 6. COLOR OR RACE Cau 7. MARRIED ☒ NEVER MARRIED ☐ B. D. TIME OF DEATH February 10, 1896 85 yrs.  
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer - (Evaluation) Dept Of Army  
11. BIRTHPLACE (State or foreign country) Wisconsin  
12. CITIZENSHIP OR WHAT COUNTRY? USA  
13. FATHER'S NAME Ole M. Bybuth  
14. MOTHER'S MAIDEN NAME Ingrio Sletmo  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown, if yes give year or dates of service) yes WW#1  
16. SOCIAL SECURITY NO. 17. INFORMANT Identification Records Dep of Army  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Coronary Occlusion  
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN A  
29a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.  
29b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, if it is a fall, etc.)  
20c. TIME OF INJURY Month Day Year 19 20d. INJURY OCCURRED While Not While at work at work  
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)  
20f. City or town  
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER [Signature]  
ASSISTANT MEDICAL EXAMINER [Signature]  
DEPUTY MEDICAL EXAMINER [Signature]  
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5/29/61 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem. 22d. LOCATION (City, town or country) Arlington, Virginia  
23. FUNERAL DIRECTOR The S. H. Hines Co. Washington, D. C. ADDRESS  
24a. REC'D BY REGISTRAR MAY 29 '61 24b. REGISTRAR SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

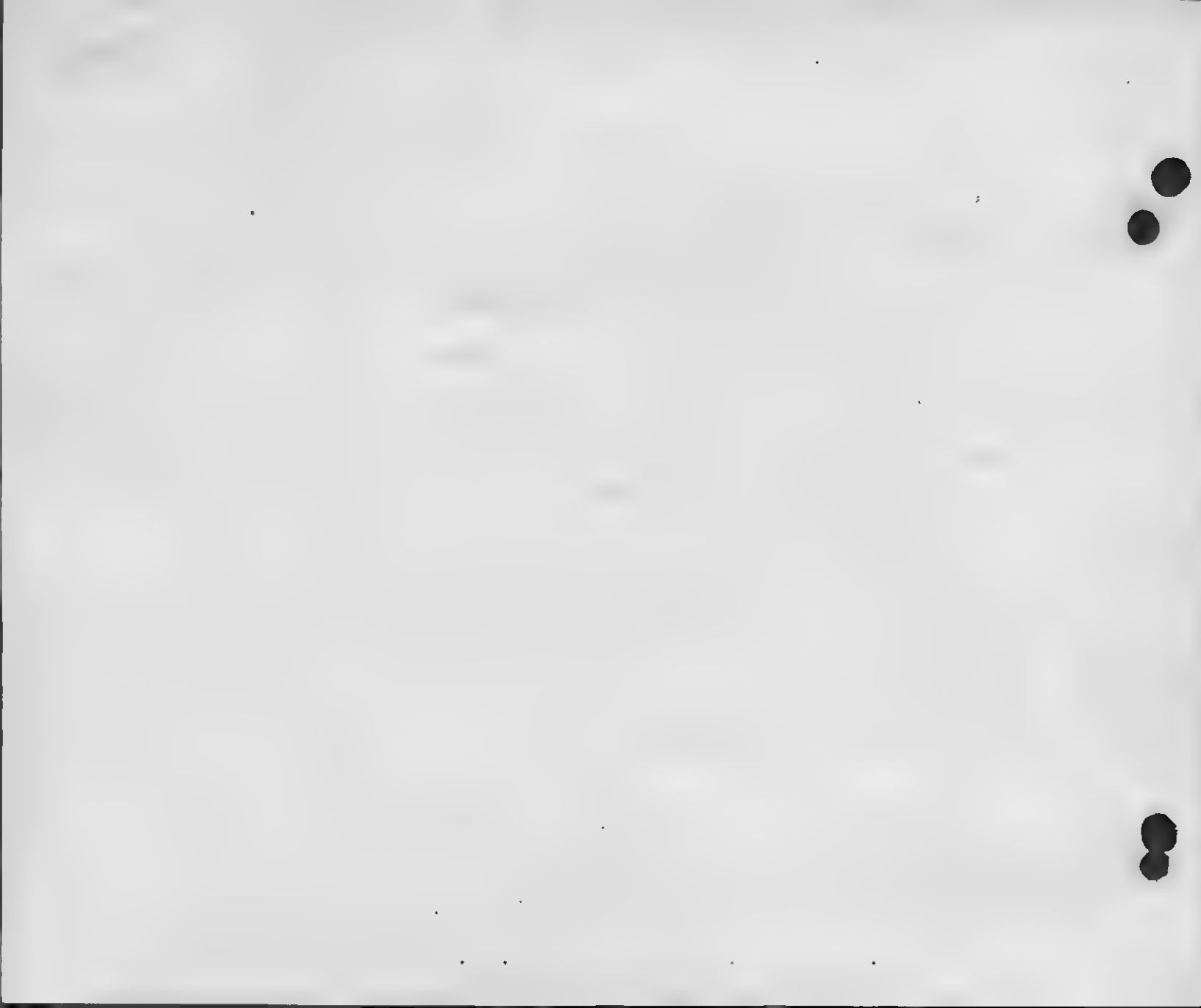
5084

05084

M

I

ON A FAP-2  
YES NO ☒



TO HO...  
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1

M

I

5095

65985

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH  
a. COUNTY **MARYLAND**  
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) **Annapolis**  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Anne Arundel General Hospital**

2. USUAL RESIDENCE (Where deceased lived. If institution, give name)  
a. STATE **Maryland**  
b. COUNTY **Anne Arundel**  
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) **Annapolis**  
d. STREET ADDRESS **410 State St.**

3. NAME OF DECEASED  
(Type or print)  
First **Sarah** Middle **CATTERTON** Last **CATTERTON**

4. DATE OF DEATH  
Month **May** Day **14** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **September 4, 1894**

9. AGE (In years last birthday) **66** yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Homemaker** 11b. KIND OF BUSINESS OR INDUSTRY **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **W. M. CATTERTON** 14. MOTHER'S MAIDEN NAME **Lily HARRIS**

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown, if yes give name and dates of service) **No** 16. SOCIAL SECURITY NO. **11-11-11-11** 17. INFORMANT **W. M. CATTERTON** Address **410 State St.**

18. CAUSE OF DEATH (Enter only or code number if so indicated)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE **Uremia, Diabetes mellitus, nephrosclerosis, hypertensive CVD, coronary artery disease**  
DUE TO **11 1/2**  
DUE TO **9 mo**  
DUE TO **14 days**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (If any, list them)  
**None**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

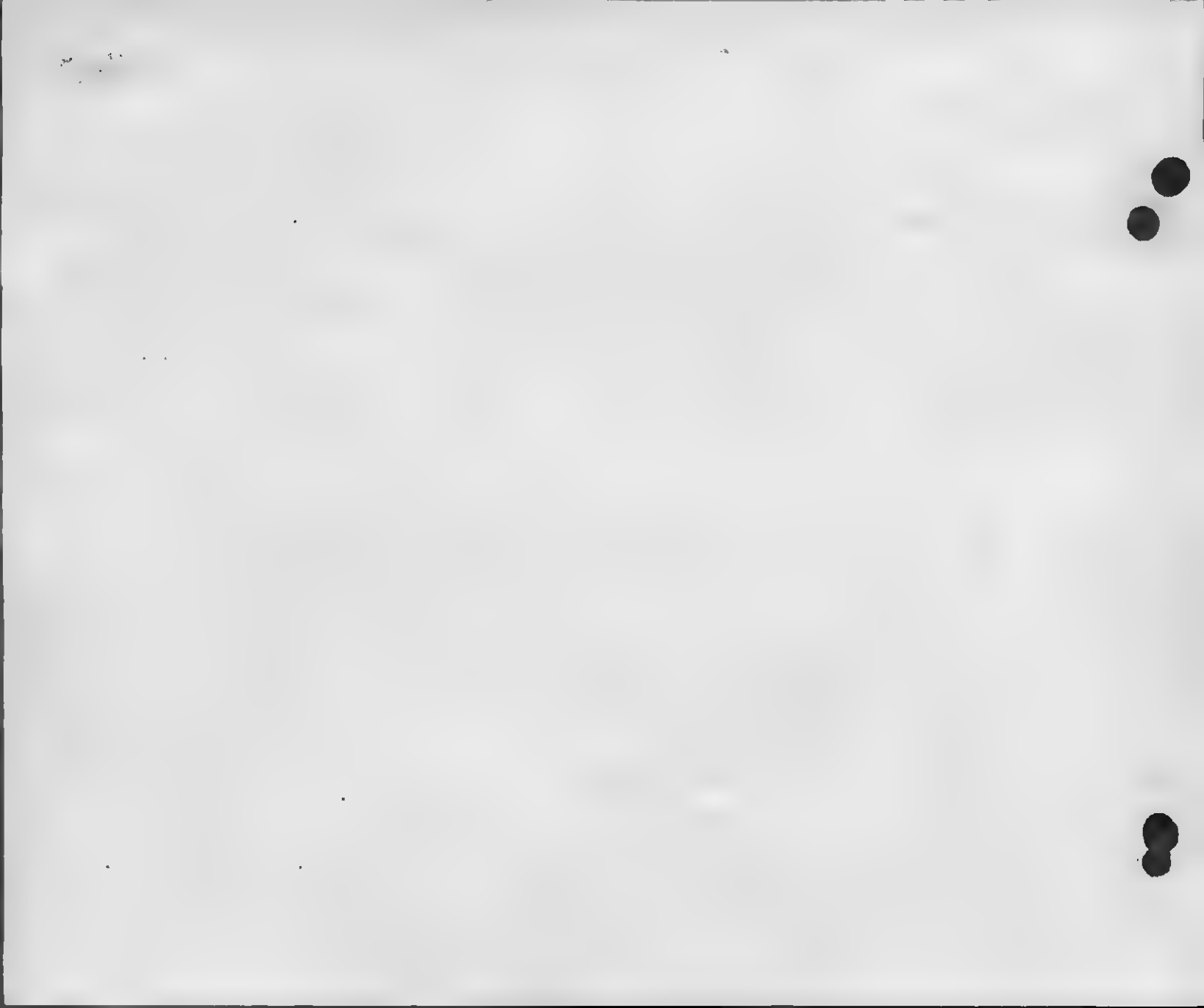
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)  
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, if so indicated)  
20c. TIME OF INJURY (Month, Day, Year) **May 13, 1961** 20d. INJURY OCCURRED (While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Home** 20f. City or town **Annapolis**

21. I certify that (I) (the undersigned) attended the deceased from **8-1** ..., 1949, to **May 14, 1961** that (I) (we) last saw the deceased alive on **May 13, 1961**, and that death occurred at **7:30 A.M.** from the causes and on the date stated above.

22. SIGNATURE **Edith Rodler** 22a. PHYSICIAN'S NAME (Type) **Edith Rodler** 22b. ADDRESS **45 Franklin St., Annapolis, Md.**

23a. BURIAL, CREMATION + 23b. DATE THEREOF **May 17, 1961** 23c. NAME OF CEMETERY OR CREMATORY **St. John's** 23d. LOCATION (City, town or county) **Annapolis**

24. FUNERAL DIRECTOR'S SIGNATURE **John W. Taylor** ADDRESS **45 Franklin St., Annapolis, Md.** 25a. REC'D BY REGISTRAR **May 17 '61** 25b. REGISTRAR'S SIGNATURE **Arthur E. Hargis**





the funeral director, Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND  
CERTIFICATE OF DEATH

5096

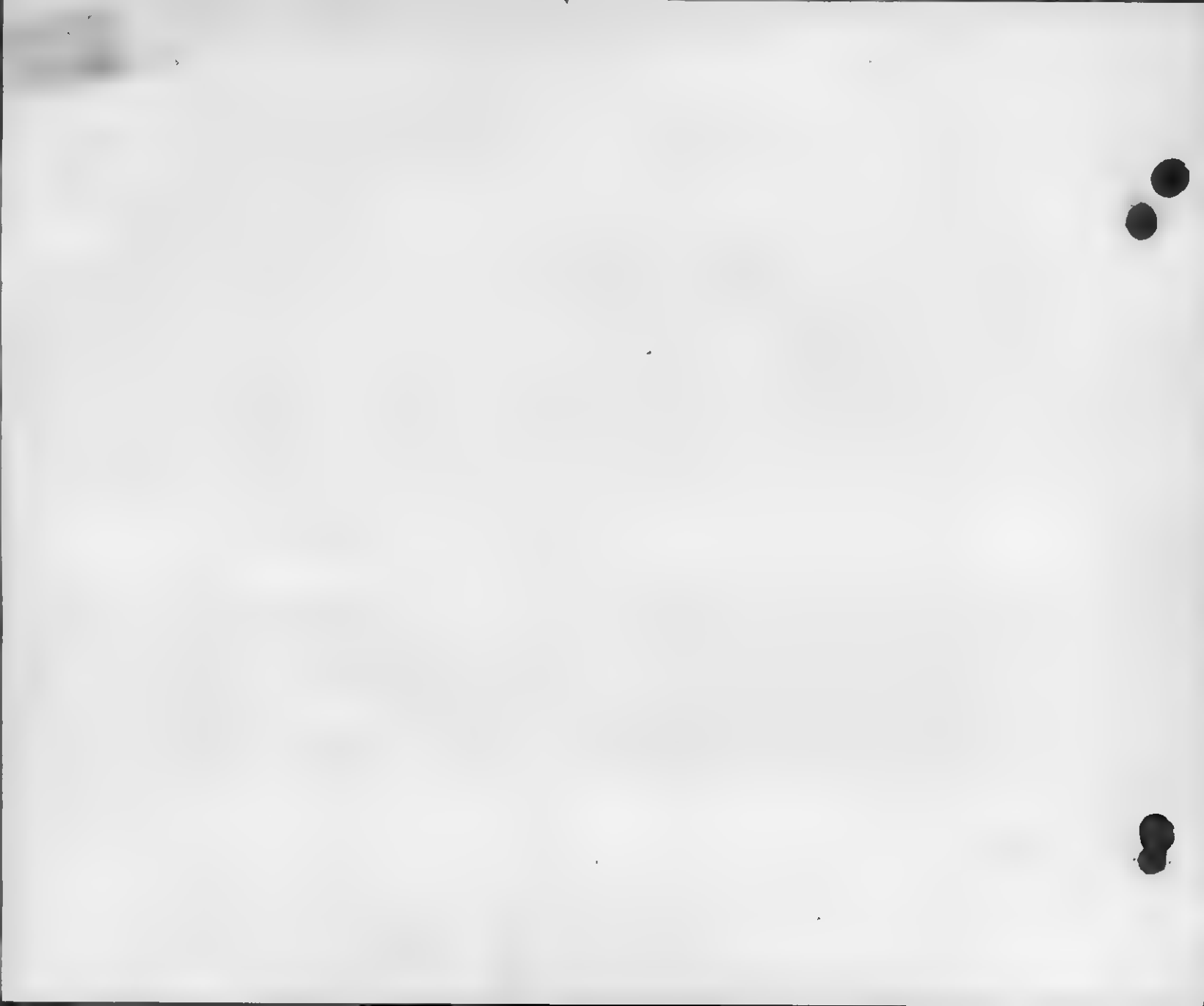
15086

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George Meade c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hosp tal, give street address) S. Army Hospital				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton d. STREET ADDRESS Rt # 1 Box 307 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last JESSIE M CHREST				4. DATE OF DEATH Month Day Year MAY 27 19 61			
5 SEX Female		6 COLOR OR RACE Cau		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 7 Jan 1887	
9 AGE (In years lost birthday) 74 yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (housework)		10b KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME David Realey		14 MOTHER'S MAIDEN NAME (unknown) Chaney			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO none		17 INFORMANT Address (SIL) Charles McAbee Same as above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a 19 W/A AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a m 19 p. m 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21 I certify that (I) (we) attended the deceased from 8 AM 27 May 19 61 to 8 PM 27 May 19 61 that (I) (we) last saw the deceased alive on 27 May 19 61 and that death occurred at 8:15 PM from the causes and on the date stated above 22a. SIGNATURE 22b. DATE 22c. PHYSICIAN'S NAME (Type) STANLEY S. SIEGELMAN, Capt., M.C. 22d. ADDRESS USA Hosp Ft Geo G Meade, Md.							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 31st May 1961		23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d LOCATION (City, town or county) (State) Woodlawn, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Glen Burnie, Maryland				25a REC'D BY REG STRAR DATE		25b REG STRAR'S SIGNATURE	

MEDICAL CERTIFICATION

I

M



Page 4  
 The law requires that the death certificate be executed within 24 hours of death.  
 The funeral director, after this certificate has been signed by the attending physician and completely filled out, should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
 Pages 1 and 2 should be filed with the funeral director. Then please remove carbon papers. Pages 3 and 4 should be detached for use as the burial-transit permit.

VR A15 (4)  
 15M 9-59

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05087

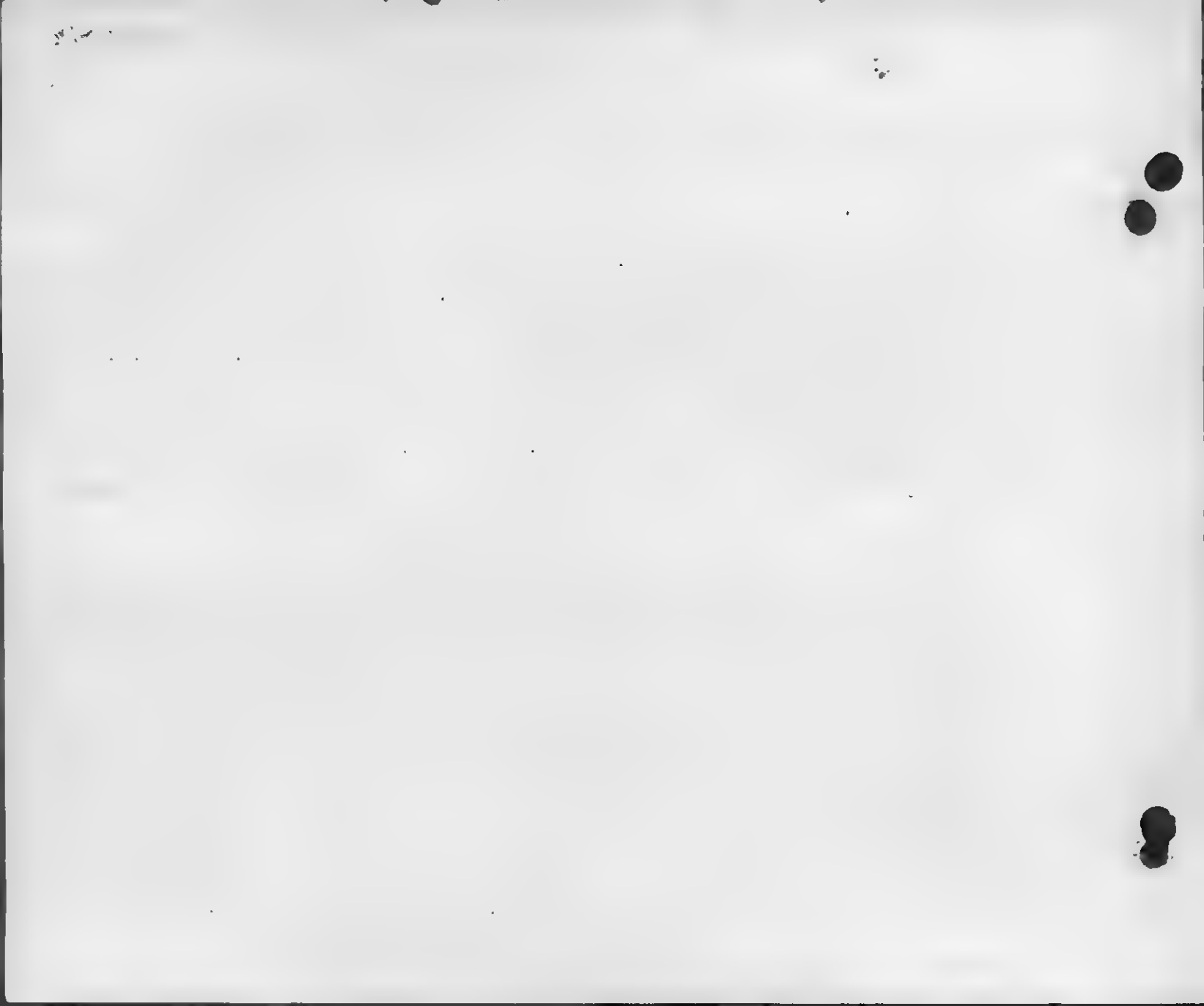
5097

1 PLACE OF DEATH a COUNTY <u>ALLEGANY</u> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived) f institution Residence before admission a STATE <u>Maryland</u> b COUNTY <u>ALLEGANY</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c LENGTH OF STAY IN 1b <u>1 year</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1115 Wilson Road</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>V.</u> Last <u>Goffman</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1961</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>11th Feb. 1880</u>	
9. AGE (in years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shorthand typewriter</u>			
11 BIRTHPLACE (State or foreign country) <u>Charlottesville, Va.</u>				12 CITIZEN OF WHAT COUNTRY? <u>  </u>			
13 FATHER'S NAME <u>Charles W. Rice</u>				14 MOTHER'S MAIDEN NAME <u>Ida (unknown)</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-11-101</u>		17. INFORMANT <u>Mr. Joseph A. Rice</u> Address <u>Same as dec'd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>  </u>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>							
20c TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a.m. <u>  </u> p.m.				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>  </u>				20f (City or town) (County) (State) <u>  </u>			
21 I certify that (I) (this hospital) attended the deceased from <u>April 15, 1961</u> to <u>May 4, 1961</u> that (I) (we) last saw the deceased alive on <u>5-1-61</u> 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above							
22a SIGNATURE <u>Nathan Racusin</u>				22b DATE SIGNED <u>5.4.61</u>			
22c PHYSICIAN'S NAME (Type) <u>NATHAN RACUSIN</u>				22d ADDRESS <u>206 S. Gilmer St. Baltimore 23, Md.</u>			
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE THEREOF <u>May 1, 1961</u>		23c NAME OF CEMETERY OR CREMATORY <u>Mount Airy M. Park</u>		23d LOCATION (City, town or county) State <u>  </u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Edward Knight</u>				25a REC'D BY REGISTRAR DATE <u>MAY 3 1961</u>			
ADDRESS <u>  </u>				25b REGISTRAR'S SIGNATURE <u>Charles P. Hines</u>			

M

1

MEDICAL CERTIFICATION



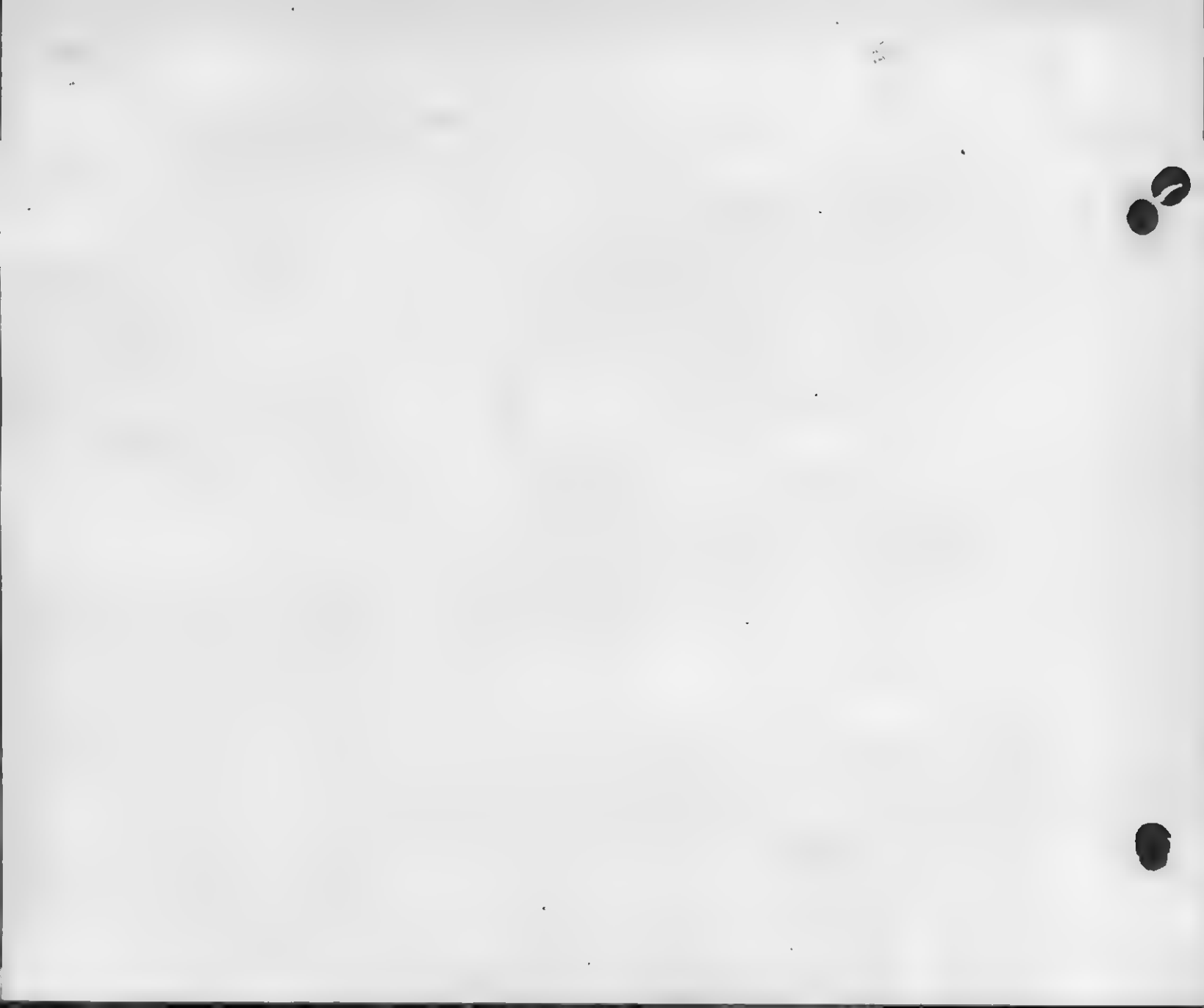
MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5098

05088

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If inst. had an address, give it.) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>226 GIBSON RD.</u>		d. STREET ADDRESS <u>410 MUNROE COURT</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>ROSIE ESTHER CONDELL</u>		4. DATE OF DEATH Month Day Year <u>5 17 1961</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-6-1896</u>
9 AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN T. CRUTCHLEY</u>		14. MOTHER'S MAIDEN NAME <u>ALICE A. SEARS</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <u>—</u>	
17 INFORMANT <u>MRS. ROBERT E. McCLANAHAN</u> Address <u>#2</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> DUE TO (c) <u>—</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anorexia nervosa</u> (b) <u>—</u> (c) <u>—</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>5/14/1961</u> to <u>5/17/1961</u> ; that (I) (we) lost the deceased alive on <u>5/17/1961</u> and that death occurred at <u>12</u> M. from the causes and on the date stated above			
22a SIGNATURE <u>General Church</u>		22b DATE SIGNED <u>5/17/61</u>	
22c PHYSICIAN'S NAME (Type) <u>GERMAN EICHEN</u>		22d ADDRESS <u>121 CALHOUN ST. ANNAPOLIS MD.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>5-20-61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		23d LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyle &amp; Sons</u>		25a REC'D BY REGISTRAR <u>MAY 22 '61</u>	
ADDRESS <u>Annapolis, Md.</u>		25b REGISTRAR'S SIGNATURE <u>C. J. Lyle</u>	

MEDICAL CERTIFICATION





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 65489

5099

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H. A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>				c. LENGTH OF STAY IN 1b <u>EDGEWATER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2 Box 244</u>				d. STREET ADDRESS <u>Route 2 Box 244</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>JOSEPH</u> Last <u>CULLINANE</u>				4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-2-1907</u>	
9. AGE (in years to birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SPECIALIST MAIL PARK SERVICE</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>TIMOTHY CULLINANE</u>				14. MOTHER'S MAIDEN NAME <u>MARY FRAWLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>DOROTHY B. CULLINANE</u> Address <u>#27</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke that was observed under</u>  <u>175X</u>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.            DUE TO (b) _____            DUE TO (c) _____</p> </div> <div style="width: 50%;"> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).  <u>None</u></p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 20) <u>Self-inflicted Gun Shot wound</u>			
20c. TIME OF INJURY Month, Day, Year <u>5/31/61</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>APAC MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural cause <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Shorrock</u> NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-3-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FINAL DIRECTOR'S SIGNATURE <u>John M. Taylor, Jr. Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>6/1</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and file, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse side, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

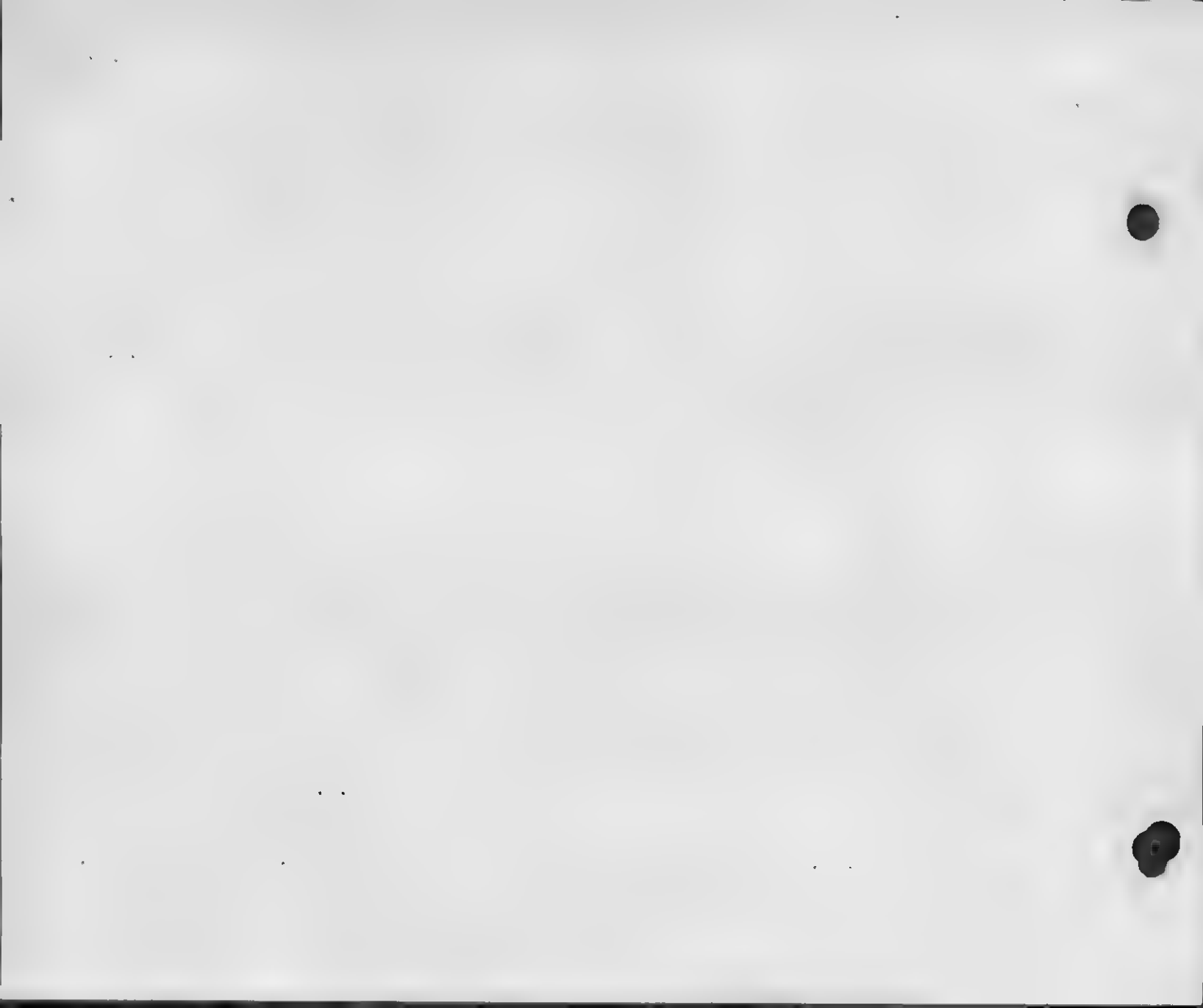
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5100

05090

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived, if different from place of death) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN IL <u>44 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>9 Arbor Hill Road</u>	
3. NAME OF DECEASED (Type or print) <u>William</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>May</u> Day <u>25</u> Year <u>1916</u>	
9. AGE (in years last birthday) <u>44 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sgt Police</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>Annapolis City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William R. Curry</u>		14. MOTHER'S MAIDEN NAME <u>S. Blanche Howes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes World War II</u>		16. INFORMANT <u>Hester M. Curry</u>	
17. CAUSE OF DEATH (Enter only or cause for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (c) <u>None</u> DUE TO (c) <u>None</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>None</u>			
19. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20a. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I) <u>None</u>			
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>None</u>			
20d. CITY OR TOWN <u>None</u>			
21. I certify that (I) <u>physician</u> attended the deceased from <u>May 16, 1961</u> to <u>May 16, 1961</u> that (I) <u>xxx</u> last saw the deceased alive on <u>May 16, 1961</u> and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. L. Anderson</u>			
22b. DATE SIGNED <u>5/17/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. L. Anderson</u>			
22d. ADDRESS <u>44 Southgate Ave., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>May 19-1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>			
23d. LOCATION (by town or county) <u>Annapolis Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>			
24a. ADDRESS <u>Annapolis Md</u>			
25a. REC'D BY REGISTRAR <u>MAY 22 61</u>			
25b. REGISTRAR'S SIGNATURE <u>None</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD 1-											
301 W. Preston St. CERTIFICATE OF DEATH											
Reg. Dist. No. 45091											
1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Skidmore</b>				c. LENGTH OF STAY IN 1b <b>10 yrs.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Skidmore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Skidmore</b>				d. STREET ADDRESS <b>Skidmore</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Ollie Dean</b>				4 DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1961</b>							
5 SEX <b>Female</b>		6 COLOR OR RACE <b>Colored</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>10-17-1876</b>		9. AGE (In years lost birthday) yrs <b>84</b>		F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11 BIRTHPLACE (State or foreign country) <b>Bolling Green, Va.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13 FATHER'S NAME <b>Unknown</b>				14 MOTHER'S MAIDEN NAME <b>Unknown</b>							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>				16 SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Wollington, Pa.</b> <b>Walter Dean - Wollington, Pa.</b>					
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>											
443X DUE TO <b>Hypertensive cardiovascular disease</b>											
Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost (c) <b>10 years</b>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)											
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 15, 1960</b> to <b>May 17, 1961</b> , that I last saw the deceased alive on <b>May 17, 1961</b> and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>Theodore H. Johnson M.D.</b>				ADDRESS (Street, city or town, state) <b>37 Calvert Street</b>				DATE SIGNED <b>May 18, 1961</b>			
PHYSICIAN'S NAME (Type) <b>Theodore H. Johnson, M. D.</b>				Annapolis, Maryland							
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-20-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rolling Green</b>				22d. LOCATION (City, town or county) (State) <b>West Chester Pa.</b>			
23 FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks 111</b>				ADDRESS <b>Annapolis Maryland</b>				24a. REC'D BY REG. STRAR DATE <b>MAY 22 1961</b>		24b. REG. STRAR'S SIGNATURE <b>C. H. S. F. F.</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5102

15092

**1. PLACE OF DEATH**  
a. COUNTY Anne Arundel **MARYLAND**  
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Annapolis  
c. LENGTH OF STAY IN b 7 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution, residence before admission)  
a. STATE Maryland b. COUNTY Anne Arundel  
c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) RURAL - Churchton  
d. STREET ADDRESS Franklin Manor  
e. IS RESIDENCE ON A FARM? ☐ YES ☒ NO

**3. NAME OF DECEASED** (Type or print)  
First Lillian Middle DePUY Last DePUY  
**4. DATE OF DEATH** Month May Day 23 Year 1961

**5. SEX** Female **6. COLOR OR RACE** White **7. MARRIED** ☐ NEVER MARRIED ☐ **8. DATE OF BIRTH** Sept. 26, 1908  
**9. AGE** (In years last birthday) 52 **10. UNDER 1 YEAR** Months 52 **11. UNDER 2 HRS.** Hours 52 Minutes 52

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Hairdresser Beauty Salon  
**10b. KIND OF BUSINESS OR INDUSTRY** New York  
**11. CITIZEN OF WHAT COUNTRY?** U.S.

**13. FATHER'S NAME** Victor Launer **14. MOTHER'S MAIDEN NAME** Serena Feher

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) No **16. SOCIAL SECURITY NO.** Robert Partos **17. INFORMANT** (2)

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE LYMPHOSARCOMA, MALIGNANT, METASTATIC  
200.1 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (IF NOT RELATED TO THE TERMINAL DISEASE INDICATED IN PART I)  
INTERVAL BETWEEN ONSET AND DEATH 2 YRS

**19. WAS AUTOPSY PERFORMED?** ☒ YES ☐ NO

**20. A CERTAIN WA UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**  
20a. TIME OF INJURY Month, Day Year 19 20b. INJURY OCCURRED While ☐ at work ☐ at work ☐ 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 1 20d. CITY OR TOWN 1

**21. I certify that (1) (the deceased) attended the deceased from...** 4-11 1960 to May 23, 1961, that (1) yes last saw the deceased alive on May 23, 1961, and that death occurred at 9:25 A.M. from the causes and on the date stated above

**22. SIGNATURE** Edward S. Beck **22b. DATE** May 23, 1961  
PHYSICIAN'S NAME (Type) Edward S. Beck **22c. ADDRESS** 71 Franklin St., Annapolis, Md.

**23. BURIAL CREMATION** 23b. DATE THEREOF May 25, 1961 **23c. NAME OF CEMETERY OR CREMATORY** Ft. Lincoln **23d. LOCATION** (City, town or county) Bladensburg Md.

**24. FUNERAL DIRECTOR'S SIGNATURE** John H. Taylor & Sons Annapolis, Md. **25a. REC'D BY REG STRAR** MAY 25 '61 **25b. REGISTRAR'S SIGNATURE** John H. Taylor

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSE: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete, fill in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5104

05094

### 1. PLACE OF DEATH

a. COUNTY

Anne Arundel

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Crownsville

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Crownsville State Hospital

### 3. NAME OF DECEASED

(Type or print)

Raymond

First

Bishop

Last

Evans

### 5. SEX

Male

### 6. COLOR OR RACE

Negro

### 7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

### 8. DATE OF BIRTH

April 5, 1892

### 9. AGE (in years IF UNDER 10 YRS IF UNDER 24 HRS

69 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Fireman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City & State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

### 13. FATHER'S NAME

John W. Evans

### 14. MOTHER'S MAIDEN NAME

Anna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-14-4081

### 17. INFORMANT

Hospital Records

Address

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Bronchopneumonia

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

Pick's Disease

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY (Month Day Year)  
Hour a.m. p.m.

20d. INJURY OCCURRED  
While at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

County

State

21. I certify that (I) (this hospital) attended the deceased from 8/6, 1957 to 5/31, 1961 that (I) (we) last saw the deceased alive on 5/31, 1961, and that death occurred at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE

L. Benedict, M. D.

22c. PHYSICIAN'S NAME (Type)

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

Crownsville State Hospital, Maryland

23a. BURIAL CREMATION REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION City town or county

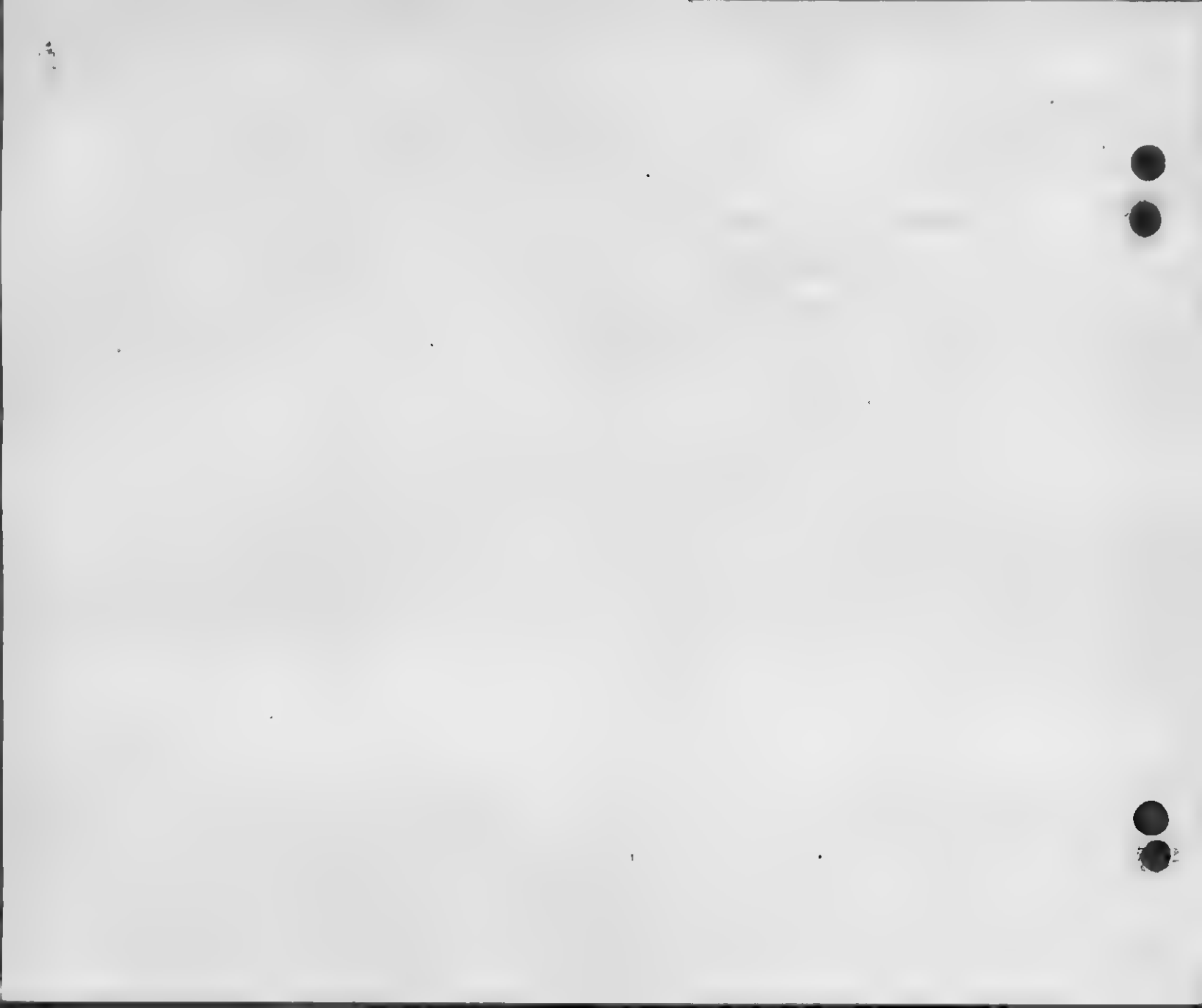
(State)

24. FUNERAL DIRECTOR'S SIGNATURE

24b. ADDRESS

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE 2 '61



**5165**

**CERTIFICATE OF DEATH**

Reg. Dist. No.

**05095**

<b>1. PLACE OF DEATH</b> a COUNTY <b>AA</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>A</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c LENGTH OF STAY IN 1b <b>Baltimore Glen Burnie</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt 1 Box 165</b>		e STREET ADDRESS <b>Rt 1 Box 165</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Rosalia Fischer</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>5 1 19 61</b>	
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 12, 1879</b>
<b>9. AGE</b> (In years last birthday) yrs <b>81</b>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min <b>19 61</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Hungary</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Hungary</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>John Kanengershur</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Bicking</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO</b> <b>Family</b>	
<b>17. INFORMANT</b> <b>Same</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>12/1X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1-2-61</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State) <b>Baltimore 29, Md</b>
<b>21. I certify that I attended the deceased from</b> <b>1961</b> <b>to</b> <b>1961</b> <b>that I last saw the deceased alive on</b> <b>12/12/61</b> <b>and that death occurred at</b> <b>5:15 P.M.</b> <b>from the causes and on the date stated above</b> ADDRESS (Street, city or town, state) <b>Baltimore, Md</b> DATE SIGNED <b>12/12/61</b>			
<b>ACTUAL SIGNATURE</b> <b>W. J. McCully</b> M.D.		<b>PHYSICIAN'S NAME (Type)</b> <b>W. J. McCully, M.D.</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>B</b>		<b>22b. DATE THEREOF</b> <b>5/4/61</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park</b>		<b>22d. LOCATION (City, town or county)</b> (State) <b>Baltimore 29, Md</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>McCully Funeral Homes 130 E. Port Ave.</b>		<b>24a. REC'D BY REGISTRAR</b> DATE <b>MAY 3 '61</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>W. J. McCully</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5106

05096

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (For use of corporations, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY (in 1b) <u>17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, residence of next of kin) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL - give street address) <u>RURAL - Harwood</u> d. STREET ADDRESS _____			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Fannie</u> Middle _____ Last <u>FISHER</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>3</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>February 26, 1873</u>			
<b>9. AGE</b> (In years last birthday) <u>88 yrs</u>		<b>10. AGE</b> (In years) IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>11. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>13. FATHER'S NAME</b> <u>George W. Owens</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>ELLEN ATWELL</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give branch and service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u> <b>17. INFORMANT</b> <u>ELIZABETH SHEPHERD HARWOOD</u> Address <u>  </u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a, b, or c) (a) <u>fracture rib (bleeding)</u> (b) <u>hypertensive pneumonia</u> (c) <u>Herpes zoster</u> DUE TO <u>  </u> DUE TO <u>  </u> DUE TO <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND CONDITION GIVEN IN PART I <u>  </u>							
<b>19. W. A. POSTMORTEM EXAMINER?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <u>  </u>					
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of form 18) <u>  </u>		<b>21. I certify that (I) (doctor) attended the deceased from April 16, 1961 to May 3, 1961 that (I) (do) saw the deceased alive on May 3, 1961, and that death occurred at M. from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Emily H. Wilson</u>		<b>22b. DATE</b> <u>10:00 P.M.</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Emily H. Wilson, M.D.</u>			
<b>22d. ADDRESS</b> <u>Lothian, Md.</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>					
<b>23b. DATE THEREOF</b> <u>May 4, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MT Zion</u>		<b>23d. LOCATION (City, town or county)</b> <u>Lothian, Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>  </u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>					

TO HO: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The certificate may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete, fill in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, it may be executed on the day after death. Give Pages 1, 2, and 3 to the Medical Examiner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-113. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The permit is valid for 72 hours after death, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 7/59

M

MEDICAL CERTIFICATE

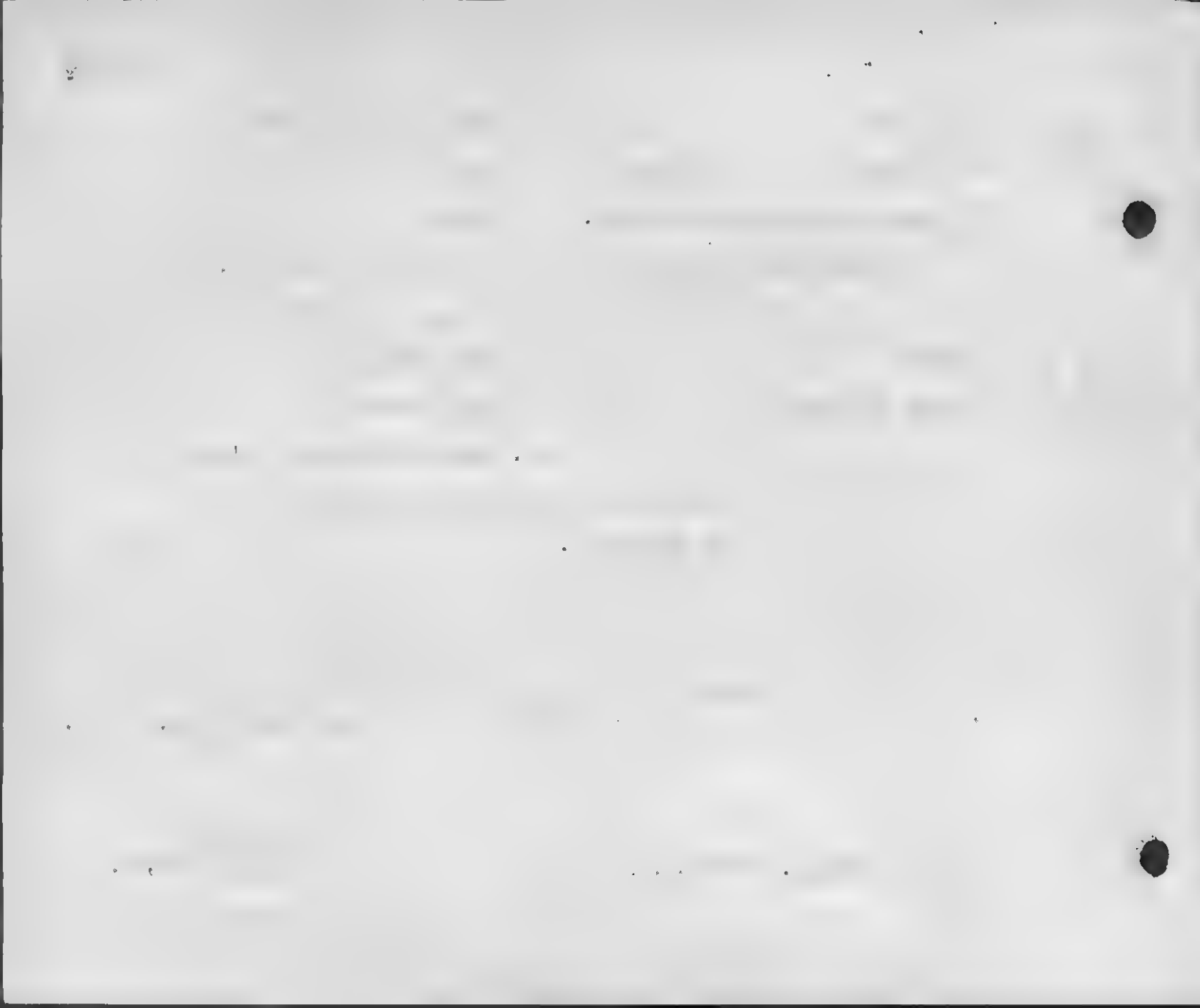
**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**5107 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** **65097**

1. PLACE OF DEATH  
a. COUNTY **Anne Arundel**  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Glen Burnie**  
c. LENGTH OF STAY IN 1b **4 years**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **102 Whip Lane, Country Club Estate.**

2. USUAL RESIDENCE (When deceased lived if different from 1b)  
a. STATE **Same**  
b. COUNTY **Same**  
c. CITY OR TOWN (If outside corporate limits, write RURAL) **Same**  
d. STREET ADDRESS **Same**

3. NAME OF DECEASED (Type or print) **George Edward Fortmiller**  
4. SEX **M**  
5. DATE OF DEATH **May 8th. 1961**  
6. TIME OF DEATH **9/6/11**  
7. MARRIED ☒ NEVER MARRIED ☐  
8. WIDOWED ☐ DIVORCED ☐  
9. AGED **49** YEARS **49** MONTHS **49** DAYS **49** HOURS **49** MIN.  
10. OCCUPATION (Give kind of work done during most of working life, even if retired) **Clerk**  
11. KIND OF BUSINESS OR INDUSTRY **Delaware**  
12. CITY OR VILLAGE OR COUNTRY **USA**  
13. FATHER'S NAME **Joseph Fortmiller**  
14. MOTHER'S MAIDEN NAME **Agnes Diepold**  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No**  
16. SOCIAL SECURITY NO. **17. INFORMANT**  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Self inflicted wound to his brain with a 10 gauge pump shot gun.**  
DUE TO (b) **Instant**  
DUE TO (c) **Instant**  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION STATED IN PART I (a), (b), and (c) **None**  
19. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.  
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) **As per #18**  
20b. TIME OF INJURY Month, Day, Year **9.30 a.m. 5/8/61**  
20c. PLACE OF INJURY (Home, farm, factory, school, office bldg., etc.) **Home**  
20d. CITY OR TOWN **Glen Burnie**  
20e. STATE **A.A.**  
20f. COUNTRY **Md.**  
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒  
death resulted from. Natural forces ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐  
ACTUAL SIGNATURE **Gustave H. Faubert, M.D.**  
EXAMINER'S NAME (Type) **Gustave H. Faubert, M.D.**  
22a. BURIAL, CREMATION, OR REMOVAL (Specify) **Crementation**  
22b. DATE THEREOF **5/9/61**  
22c. NAME OF CEMETERY OR CREMATORY **Loudon Park**  
22d. LOCATION (City, town, or country) **Baltimore, Md.**  
23. FUNERAL DIRECTOR **John S. Krouse**  
23a. REC'D BY REGISTRAR **John S. Krouse**  
23b. REGISTRAR'S SIGNATURE **John S. Krouse**  
DATE **MAY 12 '61**



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

05098

5106

PLACE OF DEATH  
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN b.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)

Anne Arundel General Hospital

3. NAME OF DECEASED  
(Type or print)

First Middle Last

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

July 17, 1960

4. DATE OF DEATH

Month Day Year

May 12, 1961

9. AGE (In y. m. d.) UNDER 1 YEAR IF UNDER 24 HRS.  
last birthday) Months Days Hours Min.

9 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State)

Anne Arundel County Md. United States

13. FATHER'S NAME

Charles R. Garrett

14. MOTHER'S MAIDEN NAME

Florine L. Wills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give service details)

16. SOCIAL SECURITY NO.

17. INFORMANT

Hospital Records, Charles R. Garrett, Jr.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Pneumonia

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c)

(b)

DUE TO

(c)

Anemia, Megaloblastic

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day Year  
Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town County State

21. I certify that I, (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above

22a. SIGNATURE

Charles R. Garrett, Jr.

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Dr. Clayton Norton

22d. ADDRESS

Medical Building

Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

Burial 5-16-1961

St. Mary's

Severna Park, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE MAY 17 '61

Charles R. Garrett, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5109

65099

### 1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

### 2. USUAL RESIDENCE (Where deceased lived 3. If institution, residence, etc.)

a. STATE

Maryland

b. COUNTY

Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

1 day +

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL - Annapolis

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

d. STREET ADDRESS

Rt-2, Box-97

### 3. NAME OF DECEASED (Type or print)

First

BABY BOY

Middle

Last

GILLIS

### 4. DATE OF DEATH

Month

May

Day

2

Year

19 61

### 5. SEX

Male

### 6. COLOR OR RACE

White

### 7. MARRIED ☐ NEVER MARRIED ☒ B. DATE OF BIRTH

April 30, 1960

### 9. AGE (In years last birthday) IF UNDER 1 YEAR IF OVER 24 HRS

Months

Days

Hours

Minutes

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

baby

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTH DATE (City & State)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

### 13. FATHER'S NAME

Gilbert John GILLIS, Jr.

### 14. MOTHER'S M.A.DEN NAME

Dolores Josephine SUMMERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL SECURITY NO.

Hospital Records

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE

Multiple congenital malformations incompatible with life.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND LONGER IN PART

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or II of certificate)

20c. TIME OF INJURY Month Day Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work Not While at work

20f. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)

21. I certify that (1) ~~(XXXXXX)~~ attended the deceased from April 30, 1961 to May 1, 1961, that (1) ~~(XXXX)~~ saw the deceased alive on May 1, 1961, and that death occurred at 2:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE

*Albert H. Anderson*

M.D.

ATTENDING PHYS ☒

M.D. DIRECTOR ☐

STAFF PHYS ☐

22b. DATE SIGNED 5/2/61

22c. PHYSICIAN'S NAME (Type)

A. L. Anderson

22d. ADDRESS

44 Southgate Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

5/3/61

23c. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

23d. LOCATION (City, town, county, State)

Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Howard H. Hubbard 4107 Wilkens Ave.

25a. REC'D BY REG. STRAR

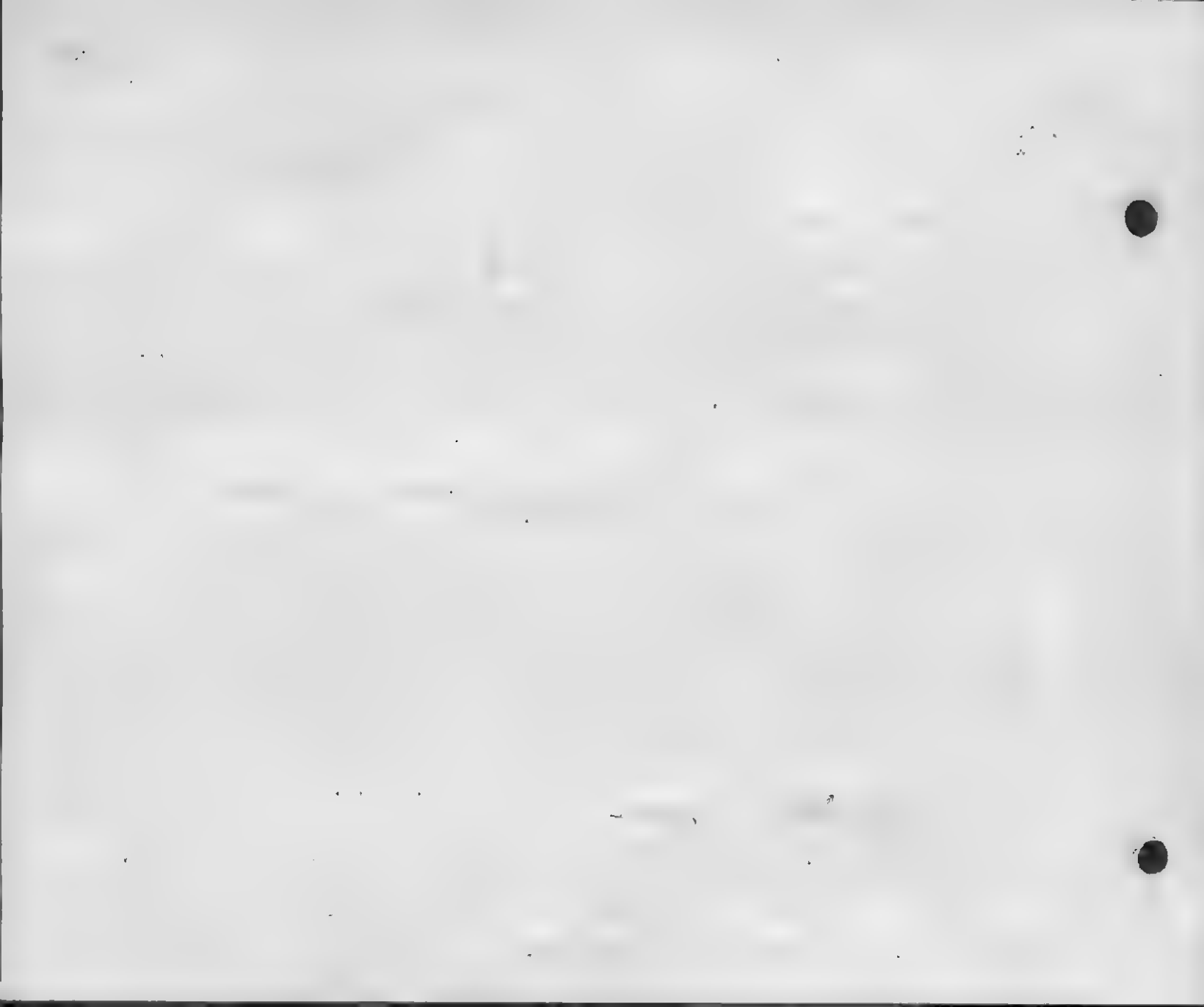
DATE MAY 4 '61

25b. REGISTRAR'S SIGNATURE

*Arthur S. Thomas*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5110

05100

1. PLACE OF DEATH  
a. COUNTY **Anne Arundel** MARYLAND  
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) **Annapolis**  
c. LENGTH OF STAY (in days) **2 days**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) **Anne Arundel General Hospital**

2. USUAL RESIDENCE Where deceased lived, if not on Res. on Date of Death (In case of death on a farm, give name of farm)  
a. STATE **Maryland** b. COUNTY **Anne Arundel**  
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) **RURAL - Annapolis**  
d. STREET ADDRESS **Defense Highway**

3. NAME OF DECEASED (Type or print) **Stephen P. GOMOLJAK**  
First Middle Last  
4. DATE OF DEATH **May 9 19 61**  
Month Day Year  
5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐  
8. AGE (in years last birthday) **63 yrs.** 9. UNDER 1 YEAR ☐ 1 YEAR ☐ 2 YEARS ☐  
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Ret. U.S. Gov. Carpenter**  
11. BUSINESS OR INDUSTRY **Anna polis, Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Joseph Gomoljak** 14. MOTHER'S MAIDEN NAME **Mary (Unknown)**

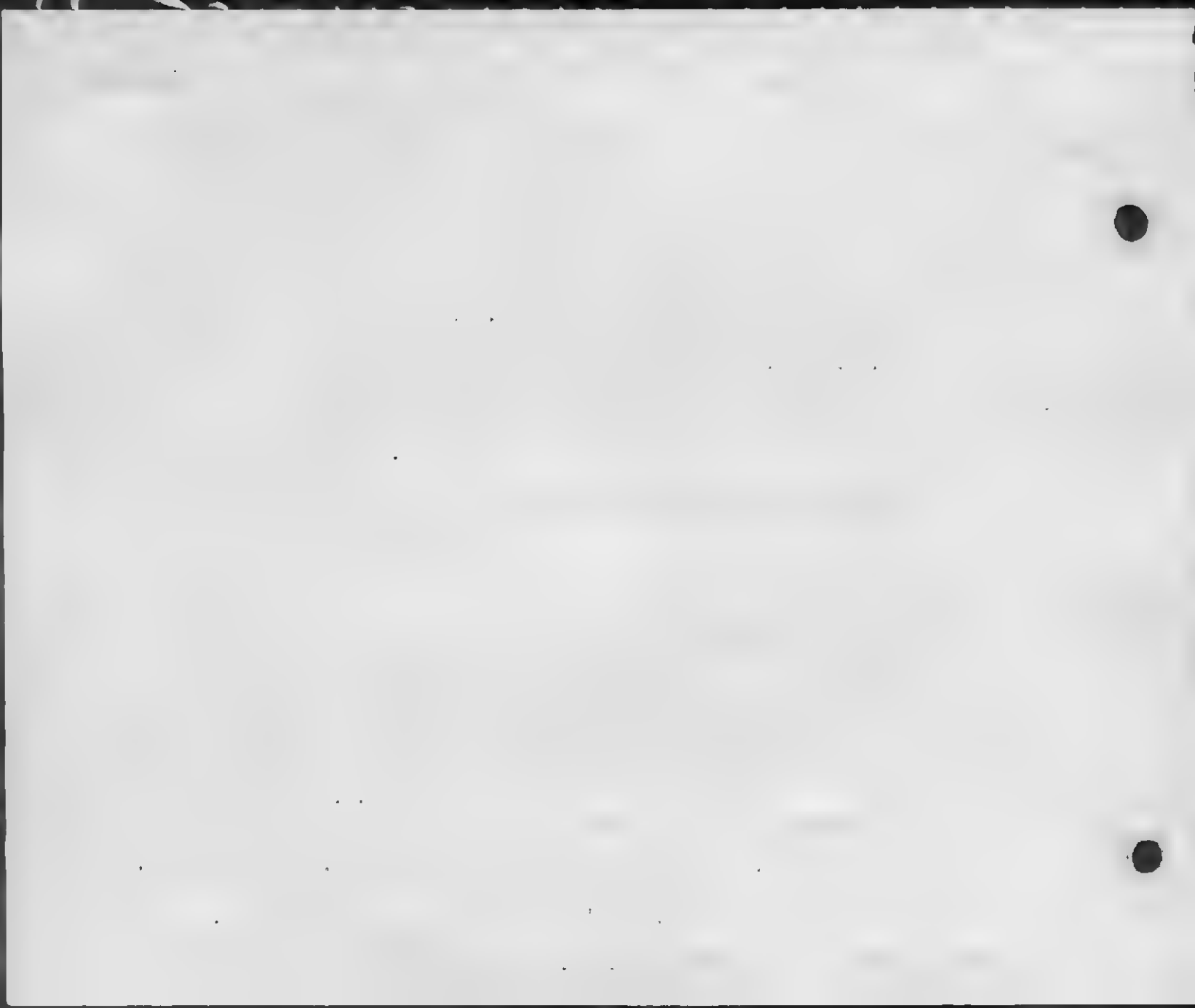
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) **no** 16. SOCIAL SECURITY NO. **none** 17. INFORMANT **Mrs. Teresa M. Gomoljak, Wife- Same as # 2**  
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **DISSECTING ANEURYSM, ABD. AORTA** (b) **2 DAYS**  
DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COMBINATION GIVEN IN PART I. **HYPERTENSIVE CARDIOVASCULAR DISEASE**  
19. Was a Topsy performed? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I. Failure to fill in Part I. Failure to fill in Part I.  
21. I certify that (I) **Edward S. Beck** attended the deceased from **May 7, 1961** to **May 9, 1961** that (I) **xx** last saw the deceased alive on **May 9, 1961**, and that death occurred at **8:55 A.M.** from the causes and on the date stated above  
22a. SIGNATURE **Edward S. Beck** 22b. DATE **5/9/61**  
22c. PHYSICIAN NAME (Type) **Edward S. Beck** 22d. ADDRESS **71 Franklin St., Annapolis, Md.**  
23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **May 13, 61** 23c. NAME OF CEMETERY OR CREMATORY **St. Mary's Cemetery** 23d. LOCATION (City, town or county) **Annapolis, Md.**  
24. FUNERAL DIRECTOR'S SIGNATURE **Hopping Funeral Home** ADDRESS **Annapolis, Md.** 25a. REC'D BY REGISTRAR **MAY 11 '61** 25b. REGISTRAR'S SIGNATURE **Charles S. Frank**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND  
CERTIFICATE OF DEATH

5111

05101

1. PLACE OF DEATH  
a. COUNTY Anne Arundel  
b. CITY OR TOWN if outside corporate limits, write RURAL and give nearest town Crownsville  
c. LENGTH OF STAY IN 1b 18 years 10 mos. 6 days  
d. NAME OF HOSPITAL OR INSTITUTION if not in hospital give street address Crownsville State Hospital

2. USUAL RESIDENCE (When deceased lived, if not in residence give last residence)  
a. STATE Maryland  
b. COUNTY Baltimore City  
c. CITY OR TOWN if outside corporate limits, write RURAL and give nearest town Baltimore  
d. STREET ADDRESS 773 Vine Street

3. NAME OF DECEASED (Type or print)  
First Middle Last Carrie Green  
4. DATE OF DEATH Month Day Year 5 24 19 61

5. SEX Female  
6. COLOR OR RACE Negro  
7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 1882  
9. AGE (In years last birthday) 78  
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired, Housework  
10b. KIND OF BUSINESS OR INDUSTRY  
11. U.S. CITIZENSHIP (Type or print for naturalized citizens) Maryland  
12. IF UNDER 1 YEAR Months Days 13. IF UNDER 24 HRS. Hours Min. 19 61  
14. MOTHER'S MAIDEN NAME Harriet Haynes  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  
16. CAUSE OF DEATH (If entirely on cause partly for b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z, aa, ab, ac, ad, ae, af, ag, ah, ai, aj, ak, al, am, an, ao, ap, aq, ar, as, at, au, av, aw, ax, ay, az, ba, bb, bc, bd, be, bf, bg, bh, bi, bj, bk, bl, bm, bn, bo, bp, bq, br, bs, bt, bu, bv, bw, bx, by, bz, ca, cb, cc, cd, ce, cf, cg, ch, ci, cj, ck, cl, cm, cn, co, cp, cq, cr, cs, ct, cu, cv, cw, cx, cy, cz, da, db, dc, dd, de, df, dg, dh, di, dj, dk, dl, dm, dn, do, dp, dq, dr, ds, dt, du, dv, dw, dx, dy, dz, ea, eb, ec, ed, ee, ef, eg, eh, ei, ej, ek, el, em, en, eo, ep, eq, er, es, et, eu, ev, ew, ex, ey, ez, fa, fb, fc, fd, fe, ff, fg, fh, fi, fj, fk, fl, fm, fn, fo, fp, fq, fr, fs, ft, fu, fv, fw, fx, fy, fz, ga, gb, gc, gd, ge, gf, gg, gh, gi, gj, gk, gl, gm, gn, go, gp, gq, gr, gs, gt, gu, gv, gw, gx, gy, gz, ha, hb, hc, hd, he, hf, hg, hh, hi, hj, hk, hl, hm, hn, ho, hp, hq, hr, hs, ht, hu, hv, hw, hx, hy, hz, ia, ib, ic, id, ie, if, ig, ih, ii, ij, ik, il, im, in, io, ip, iq, ir, is, it, iu, iv, iw, ix, iy, iz, ja, jb, jc, jd, je, jf, jg, jh, ji, jj, jk, jl, jm, jn, jo, jp, jq, jr, js, jt, ju, jv, jw, jx, jy, jz, ka, kb, kc, kd, ke, kf, kg, kh, ki, kj, kk, kl, km, kn, ko, kp, kq, kr, ks, kt, ku, kv, kw, kx, ky, kz, la, lb, lc, ld, le, lf, lg, lh, li, lj, lk, ll, lm, ln, lo, lp, lq, lr, ls, lt, lu, lv, lw, lx, ly, lz, ma, mb, mc, md, me, mf, mg, mh, mi, mj, mk, ml, mm, mn, mo, mp, mq, mr, ms, mt, mu, mv, mw, mx, my, mz, na, nb, nc, nd, ne, nf, ng, nh, ni, nj, nk, nl, nm, nn, no, np, nq, nr, ns, nt, nu, nv, nw, nx, ny, nz, oa, ob, oc, od, oe, of, og, oh, oi, oj, ok, ol, om, on, oo, op, oq, or, os, ot, ou, ov, ow, ox, oy, oz, pa, pb, pc, pd, pe, pf, pg, ph, pi, pj, pk, pl, pm, pn, po, pp, pq, pr, ps, pt, pu, pv, pw, px, py, pz, qa, qb, qc, qd, qe, qf, qg, qh, qi, qj, qk, ql, qm, qn, qo, qp, qq, qr, qs, qt, qu, qv, qw, qx, qy, qz, ra, rb, rc, rd, re, rf, rg, rh, ri, rj, rk, rl, rm, rn, ro, rp, rq, rr, rs, rt, ru, rv, rw, rx, ry, rz, sa, sb, sc, sd, se, sf, sg, sh, si, sj, sk, sl, sm, sn, so, sp, sq, sr, ss, st, su, sv, sw, sx, sy, sz, ta, tb, tc, td, te, tf, tg, th, ti, tj, tk, tl, tm, tn, to, tp, tq, tr, ts, tt, tu, tv, tw, tx, ty, tz, ua, ub, uc, ud, ue, uf, ug, uh, ui, uj, uk, ul, um, un, uo, up, uq, ur, us, ut, uu, uv, uw, ux, uy, uz, va, vb, vc, vd, ve, vf, vg, vh, vi, vj, vk, vl, vm, vn, vo, vp, vq, vr, vs, vt, vu, vv, vw, vx, vy, vz, wa, wb, wc, wd, we, wf, wg, wh, wi, wj, wk, wl, wm, wn, wo, wp, wq, wr, ws, wt, wu, wv, ww, wx, wy, wz, xa, xb, xc, xd, xe, xf, xg, xh, xi, xj, xk, xl, xm, xn, xo, xp, xq, xr, xs, xt, xu, xv, xw, xx, xy, xz, ya, yb, yc, yd, ye, yf, yg, yh, yi, yj, yk, yl, ym, yn, yo, yp, yq, yr, ys, yt, yu, yv, yw, yx, yy, yz, za, zb, zc, zd, ze, zf, zg, zh, zi, zj, zk, zl, zm, zn, zo, zp, zq, zr, zs, zt, zu, zv, zw, zx, zy, zz)

17. INFORMANT Hospital Records  
18. CAUSE OF DEATH (If entirely on cause partly for b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z, aa, ab, ac, ad, ae, af, ag, ah, ai, aj, ak, al, am, an, ao, ap, aq, ar, as, at, au, av, aw, ax, ay, az, ba, bb, bc, bd, be, bf, bg, bh, bi, bj, bk, bl, bm, bn, bo, bp, bq, br, bs, bt, bu, bv, bw, bx, by, bz, ca, cb, cc, cd, ce, cf, cg, ch, ci, cj, ck, cl, cm, cn, co, cp, cq, cr, cs, ct, cu, cv, cw, cx, cy, cz, da, db, dc, dd, de, df, dg, dh, di, dj, dk, dl, dm, dn, do, dp, dq, dr, ds, dt, du, dv, dw, dx, dy, dz, ea, eb, ec, ed, ee, ef, eg, eh, ei, ej, ek, el, em, en, eo, ep, eq, er, es, et, eu, ev, ew, ex, ey, ez, fa, fb, fc, fd, fe, ff, fg, fh, fi, fj, fk, fl, fm, fn, fo, fp, fq, fr, fs, ft, fu, fv, fw, fx, fy, fz, ga, gb, gc, gd, ge, gf, gg, gh, gi, gj, gk, gl, gm, gn, go, gp, gq, gr, gs, gt, gu, gv, gw, gx, gy, gz, ha, hb, hc, hd, he, hf, hg, hh, hi, hj, hk, hl, hm, hn, ho, hp, hq, hr, hs, ht, hu, hv, hw, hx, hy, hz, ia, ib, ic, id, ie, if, ig, ih, ii, ij, ik, il, im, in, io, ip, iq, ir, is, it, iu, iv, iw, ix, iy, iz, ja, jb, jc, jd, je, jf, jg, jh, ji, jj, jk, jl, jm, jn, jo, jp, jq, jr, js, jt, ju, jv, jw, jx, jy, jz, ka, kb, kc, kd, ke, kf, kg, kh, ki, kj, kk, kl, km, kn, ko, kp, kq, kr, ks, kt, ku, kv, kw, kx, ky, kz, la, lb, lc, ld, le, lf, lg, lh, li, lj, lk, ll, lm, ln, lo, lp, lq, lr, ls, lt, lu, lv, lw, lx, ly, lz, ma, mb, mc, md, me, mf, mg, mh, mi, mj, mk, ml, mm, mn, mo, mp, mq, mr, ms, mt, mu, mv, mw, mx, my, mz, na, nb, nc, nd, ne, nf, ng, nh, ni, nj, nk, nl, nm, nn, no, np, nq, nr, ns, nt, nu, nv, nw, nx, ny, nz, oa, ob, oc, od, oe, of, og, oh, oi, oj, ok, ol, om, on, oo, op, oq, or, os, ot, ou, ov, ow, ox, oy, oz, pa, pb, pc, pd, pe, pf, pg, ph, pi, pj, pk, pl, pm, pn, po, pp, pq, pr, ps, pt, pu, pv, pw, px, py, pz, qa, qb, qc, qd, qe, qf, qg, qh, qi, qj, qk, ql, qm, qn, qo, qp, qq, qr, qs, qt, qu, qv, qw, qx, qy, qz, ra, rb, rc, rd, re, rf, rg, rh, ri, rj, rk, rl, rm, rn, ro, rp, rq, rr, rs, rt, ru, rv, rw, rx, ry, rz, sa, sb, sc, sd, se, sf, sg, sh, si, sj, sk, sl, sm, sn, so, sp, sq, sr, ss, st, su, sv, sw, sx, sy, sz, ta, tb, tc, td, te, tf, tg, th, ti, tj, tk, tl, tm, tn, to, tp, tq, tr, ts, tt, tu, tv, tw, tx, ty, tz, ua, ub, uc, ud, ue, uf, ug, uh, ui, uj, uk, ul, um, un, uo, up, uq, ur, us, ut, uu, uv, uw, ux, uy, uz, va, vb, vc, vd, ve, vf, vg, vh, vi, vj, vk, vl, vm, vn, vo, vp, vq, vr, vs, vt, vu, vv, vw, vx, vy, vz, wa, wb, wc, wd, we, wf, wg, wh, wi, wj, wk, wl, wm, wn, wo, wp, wq, wr, ws, wt, wu, wv, ww, wx, wy, wz, xa, xb, xc, xd, xe, xf, xg, xh, xi, xj, xk, xl, xm, xn, xo, xp, xq, xr, xs, xt, xu, xv, xw, xx, xy, xz, ya, yb, yc, yd, ye, yf, yg, yh, yi, yj, yk, yl, ym, yn, yo, yp, yq, yr, ys, yt, yu, yv, yw, yx, yy, yz, za, zb, zc, zd, ze, zf, zg, zh, zi, zj, zk, zl, zm, zn, zo, zp, zq, zr, zs, zt, zu, zv, zw, zx, zy, zz)

19. INTERVIEWED BY (Name and address)  
20. DATE OF INTERVIEW (Month, Day, Year)  
21. I certify that (I) (this hospital) attended the deceased from 5/11 1961, to 5/24 1961, that (I) (we) last saw the deceased alive on 5/24 1961, and that death occurred at 1:40 PM, from the causes and on the date stated above  
22. SIGNATURE Hildegard Heard Reissman, M.D.  
23. PHYSICIAN'S NAME (Type)  
24. ADDRESS Crownsville State Hospital, Maryland  
25. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
26. DATE MAY 31 '61

23a. BURIAL, CREMATION, 23b. DATE THEREOF  
23c. NAME OF CEMETERY OR CREMATORY  
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE  
25. ADDRESS  
26. DATE



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film B-28 6/2/61 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No. **U5102**

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Shady Side Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Eugenia</u> First <u>Grass</u> Middle Last		4 DATE OF DEATH <u>May 21</u> 19 <u>61</u> Month Day Year	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Feb. 18, 1883</u> 78 yrs.
9. AGE (in years last birthday)		F UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Churchton, Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Nick</u>		14 MOTHER'S MAIDEN NAME <u>unknown</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>?</u>	
17. INFORMANT		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I attended the deceased from <u>May 11</u> 19 <u>61</u> , to <u>May 21</u> 19 <u>61</u> , that I last saw the deceased alive on <u>May 21</u> 19 <u>61</u> , and that death occurred at <u>7:15 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frederick Smith</u> M.D.		DATE SIGNED <u>May 26</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>			
22a BURIAL, CREMATION, OR REMOVAL (Specify)	22b DATE THEREOF <u>May 24, 1961</u>	22c NAME OF CEMETERY OR CREMATORY <u>Frederick Cemetery</u>	22d LOCATION (City, town, or county) (State)
23 FUNERAL DIRECTOR'S SIGNATURE <u>Bernard H. H. H.</u> ADDRESS <u>Baltimore, Md.</u>		24b REGISTRAR'S SIGNATURE <u>Arthur S. H. H.</u>	
24a REC'D BY REGISTRAR DATE <u>MAY 29 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5113  
CERTIFICATE OF DEATH

05103

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND  
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Annapolis  
c. LENGTH OF STAY IN 1b 9 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived if institution Residence before death)  
a. STATE Maryland b. COUNTY Anne Arundel  
c. CITY OR TOWN (if outside corporate limits write RURAL) RURAL - Edgewater  
d. STREET ADDRESS Rt-2, Box-130  
e. RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) Matilda First Middle Last  
4. DATE OF DEATH May 22 1961  
5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Jan. 31, 1895  
9. AGE (In years last birthday) 66 yrs IF UNDER 1 YEAR 10. IN U.S. ☒ HRS  
11. CITIZEN OF WHAT COUNTRY? U.S.

12. FATHER'S NAME 13. MOTHER'S MAIDEN NAME  
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) 15. SOCIAL SECURITY NO 16. INFORMANT Address  
17. CAUSE OF DEATH (Enter only or cause of death)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a. Myocardial Infarction of Left & Right Coronary Arteries  
b. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause: Diabetes Mellitus  
PART II. OTHER SIGNIFICANT CONDITIONS PREEXISTING AT DEATH OR RELATED TO TERMINAL DISORDER: 18. DATE OF ONSET AND DEATH 9 days  
19. DATE OF EXAMINATION 5/23/61  
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner) YES ☒ NO ☐

20a. TIME OF INJURY Hour a.m. 19 p.m. 20b. INJURY OCCURRED While at work Not While at work  
21. I certify that I, R. L. Richardson, attended the deceased, from May 13, 1961 to May 22, 1961, and that death occurred at 1:20 P.M. on May 22, 1961, and that death occurred at 1:20 P.M. from the causes and on the date stated above.

22. SIGNATURE R. L. Richardson  
22a. PHYSICIAN'S NAME (Type) R. L. Richardson  
22b. ADDRESS 110 Clay St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-27-1961 23c. NAME OF CEMETERY OR CREMATORY Brentwood Hill Cemetery, Annapolis, Md.  
24. FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
DATE MAY 24 '61

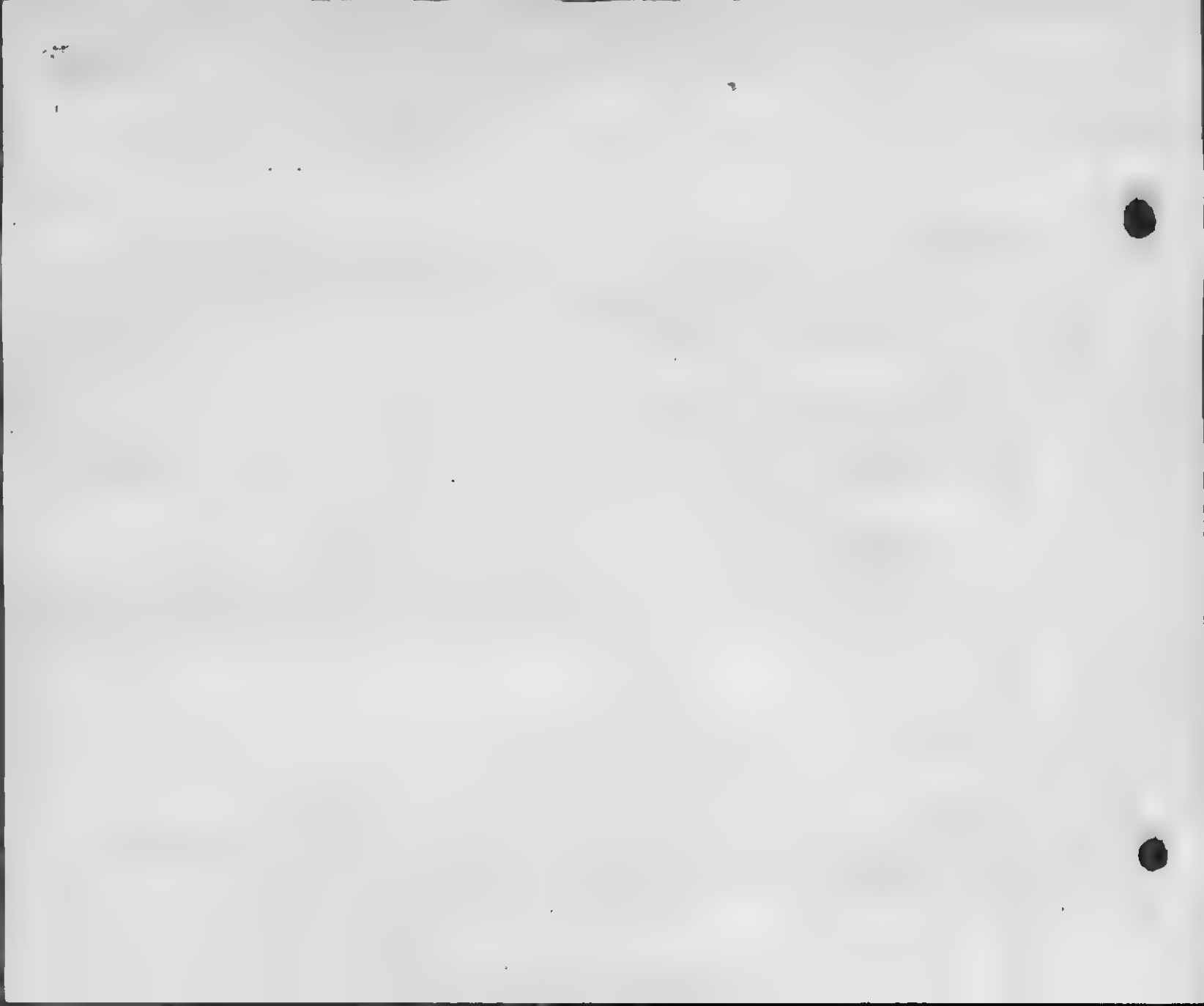


# 1 FOR STATE HEALTH DEPT. TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 5114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05104

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARYLAND</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		3. NAME OF DECEASED (Type or print) <b>Joseph</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>COL.</b>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>5.20.04</b>		9. AGE (In years last birthday) <b>56 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. GOV'T.</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>			
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <b>JAMES HAMM</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH ?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>1.5.60V1</b>			
17. INFORMANT <b>MRS. GERTRUDE H. HAMM</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic heart disease.</b> DUE TO (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>WASHINGTON, D.C.</b>		20g. (County)		20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5.27.61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEM. CEM.</b>		22d. LOCATION (City, town, or country) <b>SUITLAND, MARYLAND</b>			
23. FUNERAL DIRECTOR <b>ROBERT J. McGUIRE</b>		24a. REC'D BY REGISTRAR <b>May 25, 1961</b>		24b. REGISTRAR'S SIGNATURE <b>May 25, 1961</b>		24c. ADDRESS (Street, city, town or county) <b>1000 9TH ST., N.W.</b>		24d. ADDRESS (Street, city, town or county) <b>WASHINGTON, D.C.</b>			





5115

CERTIFICATE OF DEATH

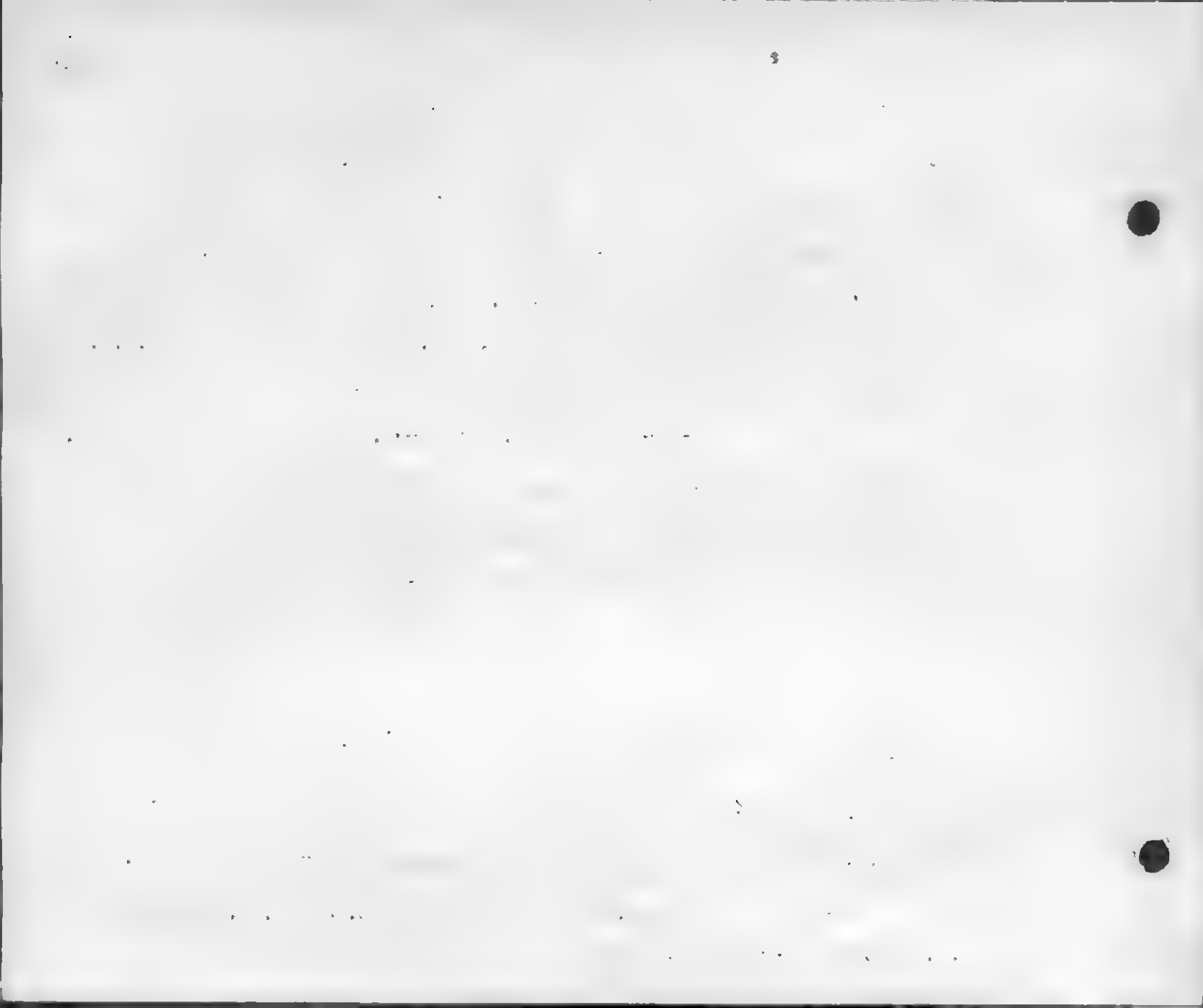
Reg. Dist No. 05105

1 PLACE OF DEATH a COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a STATE <b>Maryland</b> b COUNTY <b>Anne Arundel</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>		c LENGTH OF STAY IN 1b <b>Life</b>	
d NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>Route 2 - Box 430</b>		d STREET ADDRESS <b>Route 2 Box 430</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Timothy ( Tim ) Julius Harris</b>		4 DATE OF DEATH Month Day Year <b>May 6 19 61</b>	
5 SEX <b>Male</b>	6 COLOR OF RACE <b>Colored</b>	7- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14-1891</b>
9 AGE (in years lost birthday) <b>70</b> yrs		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmers - Helper</b>		10b KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11 BIRTHPLACE (State or foreign country) <b>A.A.Co. Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Julius Harris</b>		14. MOTHER'S MAIDEN NAME <b>Louise Colbert</b>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>214-18-7669</b>	
17 INFORMANT <b>Ida R. Harris-Rt. 2-Box 430</b>		Address <b>Annapolis, Md.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>151X</b> DUE TO <b>Cardiac arrest</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>with no known</b> DUE TO <b>metals again</b> (c) <b>metals again</b> PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-4-61</b> , 19 to <b>5-6-61</b> , 19, that I last saw the deceased alive on <b>5-4-61</b> , 19, and that death occurred at <b>7:30</b> M. from the causes and on the date stated above. ACTUAL SIGNATURE <b>C. E. Hicks</b> ADDRESS (Street, city or town, state) <b>Cathedral Street-Annapolis, Md.</b> DATE SIGNED <b>MAY 9 '61</b>			
22a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b DATE THEREOF <b>5-9-61</b>	
22c NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>		22d LOCATION (City, town, or county) (State) <b>Rt. 2 A.A.Co. Maryland</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>C.E.Hicks III</b>		ADDRESS <b>Annapolis, Maryland</b>	
24a REC'D BY REGISTRAR <b>MAY 9 '61</b>		24b REGISTRAR'S SIGNATURE <b>C. E. Hicks</b>	

Page 4

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HO. L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5116 05106

1. PLACE OF DEATH  
a. COUNTY Anne Arundel  
b. CITY OR TOWN (If rural, give nearest town) Annapolis  
c. LENGTH OF STAY IN 43 years  
d. NAME OF HOSPITAL OR INSTITUTION (If not) 407 Severn Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution, give name)  
a. STATE Maryland  
b. COUNTY Anne Arundel  
c. CITY OR TOWN (If outside of corporate limits, give nearest town) Annapolis  
d. ADDRESS 407 Severn Avenue

3. NAME OF DECEASED (Type or print)  
First Frances Middle Isabelle Last Hartge

4. DATE OF DEATH  
Month 5 Day 29 Year 1961

5. SEX F 6. COLOR W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. AGE (In years, months, days, hours, minutes)  
Years 74 Months 0 Days 0 Hours 0 Minutes 0

10. OCCUPATION (If deceased was engaged in occupation, give name of occupation)  
Housewife 11. HOME U.S.

12. FATHER'S NAME W.T. Rogers 13. MOTHER'S MAIDEN NAME Alverta Atwell

14. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) No 15. INFORMANT Louis Hartge Address 407 Severn Ave, Annapolis

16. CAUSE OF DEATH (In only one or more of the following)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Generalized metastases  
DUE TO Undifferentiated transitional cell carcinoma of bladder  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
DUE TO 1 year  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. None

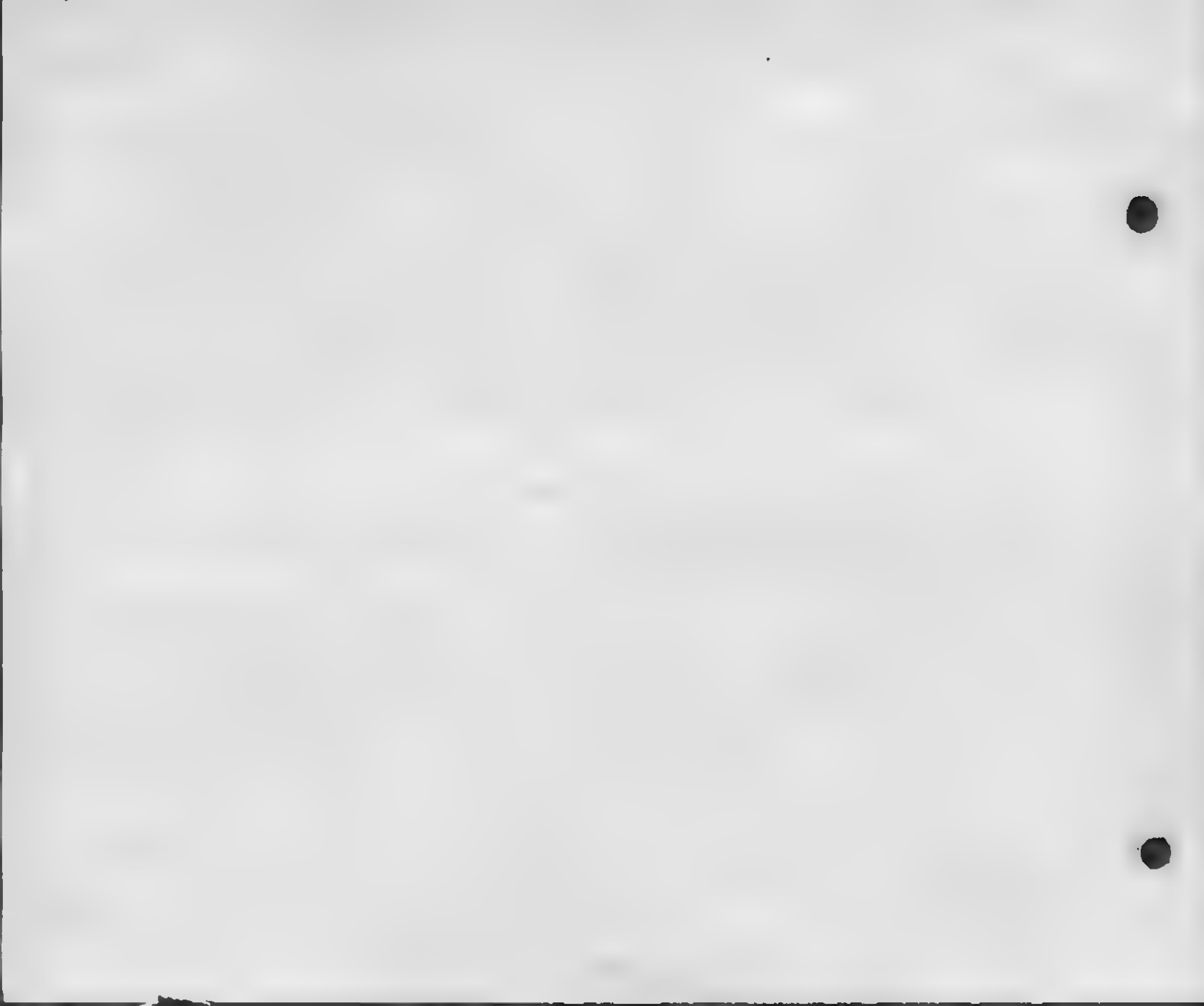
17. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)  
20a. TIME OF INJURY Month, Day, Year 19 20b. INJURY OCCURRED While ☐ Not While ☐ 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 100 Cathedral Street, Annapolis, Md.

21. I certify that (I) (the hospital) attended the deceased from March 1, 1961, to May 29, 1961, that (I) (the hospital) saw the deceased alive on 5/29, 19 61, and that death occurred at 10:15 AM, from the causes and on the date stated above.

22a. SIGNATURE Richard I. Hochman, M.D. 22b. DATE 5/29/61  
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D. 22d. ADDRESS 100 Cathedral Street, Annapolis, Md.

23a. BURIAL OR CREMATION BURIAL 23b. DATE THEREOF 5-31-61 23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF 23d. LOCATION City, town or county ANNAPOLIS MD.

24. FUNERAL DIRECTOR'S SIGNATURE John W. [Signature] ADDRESS Annapolis, Md. 25a. REC'D BY REGISTRAR DATE JUN 2 '61 25b. REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

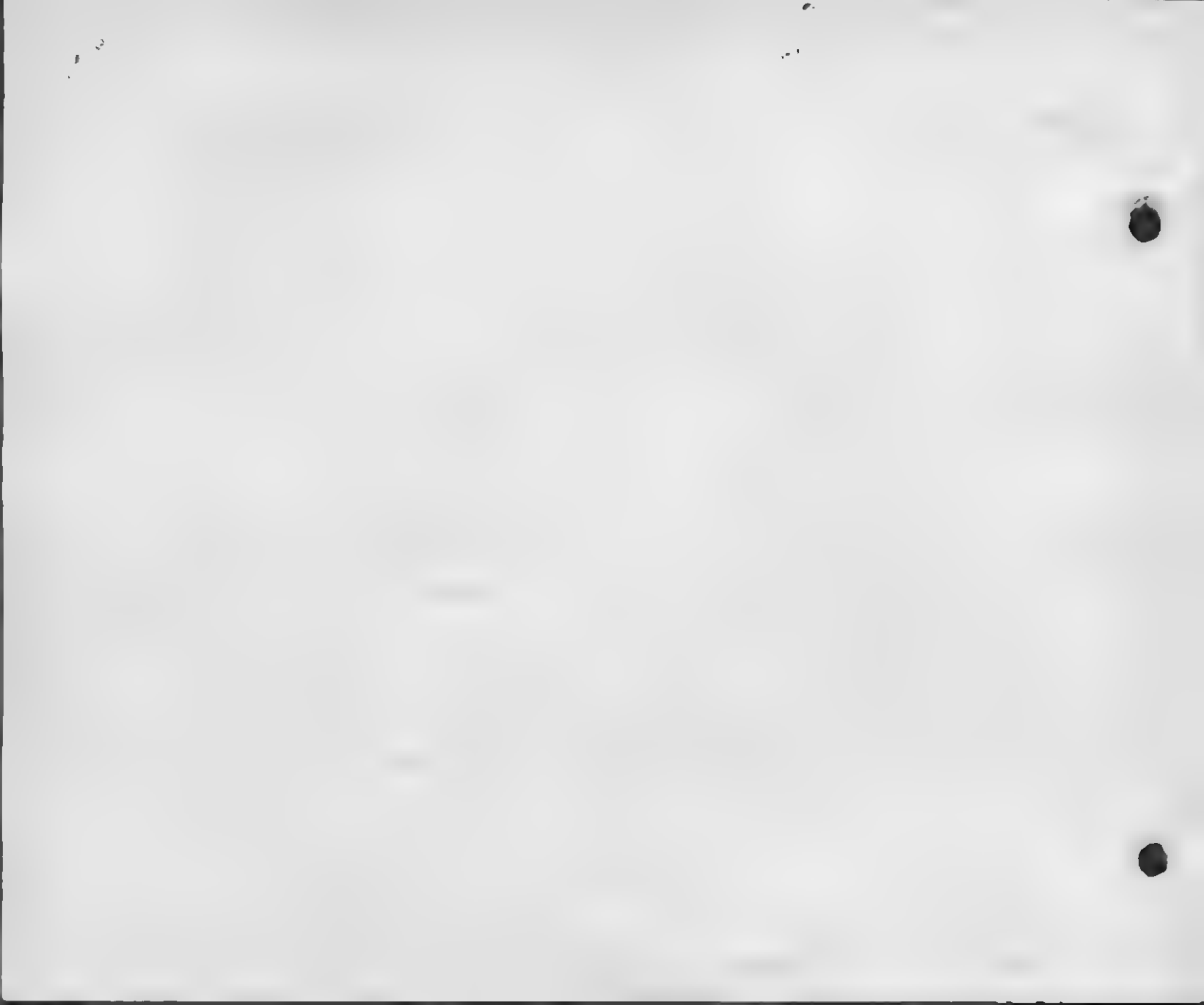
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5117

05107

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, name of institution) e. STATE <u>MARYLAND</u> b. COUNTY <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILKES BARRE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILKES BARRE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WILKES BARRE HOSPITAL</u>		STREET ADDRESS <u>1015 WILKES BARRE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>E</u> Last <u>HEINRY</u>		4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years, last birthday) YEARS <u>34</u> MONTHS <u>3</u> DAYS <u>27</u>
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. FATHER'S NAME <u>EDWARD HEINRY</u>		14. MOTHER'S MAIDEN NAME <u>MARY FRAMPTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16. SOCIAL SECURITY NO. <u>1-17-44-11111</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Dehydration &amp; malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Dehydration</u> (c) <u>Starvation, colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>WILKES BARRE</u> County <u>LUZERNE</u> State <u>PA</u>	
21. I certify that ( ) (this hospital) attended the deceased from <u>5-4-1960</u> to <u>5-27-1961</u> , that (I) (we) last saw the deceased alive on <u>5-17-1961</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Barry G. V. [Signature]</u>		22b. DATE SIGNED <u>5-31-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Barry G. V. [Signature]</u>		22d. ADDRESS <u>4111 [Address]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) State	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 1 '61</u>	
ADDRESS <u>4111 [Address]</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>	



1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u>		b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1 da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>930 W. Pratt St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith</u>		F. rst M. ddle L. ast <u>M. Hirschmann</u>		4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/12/1893</u>	
9. AGE in years last birthday <u>67</u> yrs		F. UNDER YEAR 15 N. 16 & 17 HRS. Months <u>6</u> Days <u>7</u> Hours <u>10</u> Min <u>00</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Russell</u>				14. MOTHER'S MAIDEN NAME <u>Anna Franklin</u>			
15. WAS DECEASED IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Dr. Charles R. Hirschmann Sr.</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>							
DUE TO (b) <u>Hypertensive cardiac - Vas de re</u>							
DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 10</u> , 19 <u>61</u> , to <u>—</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>MAY 11</u> , 19 <u>61</u> and that death occurred at <u>5 P</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Charles Tommasello</u>				22b. ADDRESS <u>910 W. Lombard St. Baltimore</u>		22c. DATE SIGNED <u>5/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles Tommasello</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/13/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Connerdon</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	





may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05109

5113

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 1- Box 195</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>J.</u> Last <u>Holm</u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1961</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Feb. 1898</u>		9. AGE (In years last birthday) <u>83</u> yrs	IF UNDER 1 YEAR IF UNDER 4 YRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Heating Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>New Orleans, La</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius Holm</u>				14. MOTHER'S MAIDEN NAME <u>(Unknown) Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I.</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs. Mamie I. Holm</u>		Address <u>SAME as NAT</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>							
DUPLICATE <u>422.1</u> DUE TO (b) <u>Obvicular Triangular</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>in his seizure. chronic I.V. disease</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 15, 1961</u> , to <u>May 20, 1961</u> , that I last saw the deceased alive on <u>5-17</u> , 19 <u>61</u> , and that death occurred at <u>11:20</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED <u>5-20</u>	
ACTUAL SIGNATURE <u>[Signature]</u> M D							
PHYSICIAN'S NAME (Type) <u>Robert F. Ware - Glen Burnie, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>24-May-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l. Cemetery Baltimore - Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton &amp; Son, Inc. Home</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE	
						DATE <u>May 23, 1961</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a physician is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05110

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Westminster</u> <u>54 Liberty Street</u>	
3. NAME OF DECEASED (Type or print) <u>CARVEL</u> <u>HORTON</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-21-1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S.R. C.</u>	9. AGE (In years last birthday) <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard M. Horton</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Wagner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes</u> <u>W.W. 1</u>		16. SOCIAL SECURITY NO. <u>218-05-1403</u>	
17. INFORMANT <u>Mrs. Zelda L. Horton, same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>977.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>5/21/61</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Westminster</u> <u>Carroll</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Russell S. Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED <u>5/22/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-24-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens</u>
23. FUNERAL DIRECTOR <u>C. M. Waltz,</u>		22d. LOCATION (City, town, or country) (State) <u>Finksburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>C. M. Waltz</u>		24b. REGISTRAR'S SIGNATURE <u>C. M. Waltz</u>	
DATE <u>MAY 24 '61</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

051111

5121

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 1 1/2 days

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence, b. or admission)  
a. STATE Maryland b. COUNTY Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Harwood

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last Bertram Leon IRELAND

4. DATE OF DEATH Month Day Year May 9 1961

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH May 8, 1961

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Mins 1 11 53

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital records. 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (County & State or foreign country) U.S.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Frank M. IRELAND 14. MOTHER'S MAIDEN NAME Elsie Louise PADDY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Hospital records. Address

18. CAUSE OF DEATH (Enter only one cause per line for a b c d e f g h i j k l m n o p q r s t u v w x y z) Perinatal

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) 776X DUE TO 1 day

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AN AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter no use of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town 20g. County 20h. State

21. I certify that (I) (Signature) attended the deceased from May 8, 1961 to May 9, 1961, that (I) (Signature) saw the deceased alive on May 9, 1961, and that death occurred at 2:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE (Signature) 22b. DATE SIGNED May 9, 1961

22c. PHYSICIAN'S NAME (Type) Stuart H. Walker 22d. ADDRESS 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-11-61 23c. NAME OF CEMETERY OR CREMATORY Mt Zion 23d. LOCATION (City, town or county) Lothidg (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE (Signature) ADDRESS (Signature) 25a. REC'D BY REGISTRAR May 17 '61 25b. REGISTRAR'S SIGNATURE (Signature)

TO HO... TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

VS. A15ML  
5M 7/59

TO DE. JY MEDICAL EXAMINER: This certificate should be executed within 24 hours after  
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. P.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

with If

may be necessary,  
Director, Page  
1142

FOR  
HEALT

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 5122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05112

STATE  
DEPT.

M

1 PLACE OF DEATH  
a. COUNTY

Anne Arundel

MARYLAND

2. USUAL RESIDENCE (Where dec. died lived. If institution, Reside. & Adm. in)

b. STATE  
Maryland

b. COUNTY  
A.A.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore 25

c. LENGTH OF STAY IN 1b

Few instants

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore 25

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Johnson used ears lot, Belle Grove Rd.

d. STREET ADDRESS

25 Nann Ave.

3 NAME OF DECEASED  
Type of name

George Leroy Isaacs Jr.

4 DATE OF DEATH

May the tenth 19 61

5 SEX

M

6 COLOR OR RACE 7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

12/8/24

9 AGE (by last birthday) Months | Days | Hours | Min

36 yrs

10a. OCCUPATION (Kind of work done during most of working life, even if retired)

Mechanic

10b. KIND OF BUSINESS OR INDUSTRY

Anchor Meter Art.

11. BIRTHPLACE (State or foreign country)

Brooklyn, N.Y.

12. CITIZENSHIP (What country?)

USA

13. FATHER'S NAME

George Leroy Isaacs

14. MOTHER'S MAIDEN NAME

Jessie A. Gray

15. WAS DECEASED EVER UNDER ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

144-18-1489

17. INFORMANT

Mrs. Mary Isaacs, (wife) Same

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE or

Strangulation, by hanging himself with a rope.

INTERVAL BETWEEN ONSET AND DEATH  
Sudden

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) DUE TO

19. CHECK IN PLANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

Tied one end of rope around his neck and the other end to a hook (screwed to apoll)

21. TIME OF INJURY (M, A, P, D, S, Yr) 7:35 5/10/61

22a. PLACE OF INJURY (Where)

At work ☐ Not at work ☒

22b. PLACE OF INJURY (Home, farm, city, street, office, bldg, etc)

Bellegrove Rd.

Baltimore 25, A.A.

Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Autopsy ☒

death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

CHIEF MEDICAL EXAMINER ☐

M.D.

ASS STANT MEDICAL EXAMINER ☐

5/10/61

DATE SIGNED

EXAMINER'S NAME (T)

Gustave H. Faubert, M.D.

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

May 15, 1961

22c. NAME OF CEMETERY OR CREMATORY

Shore Land Mem. Gardens

22d. LOCATION (City, town, or county)

Keyport, New Jersey

23. FUNERAL DIRECTOR

ADDRESS

4001 Ritchie Hwy. Balto 25

24a. REC'D BY REG. TRK

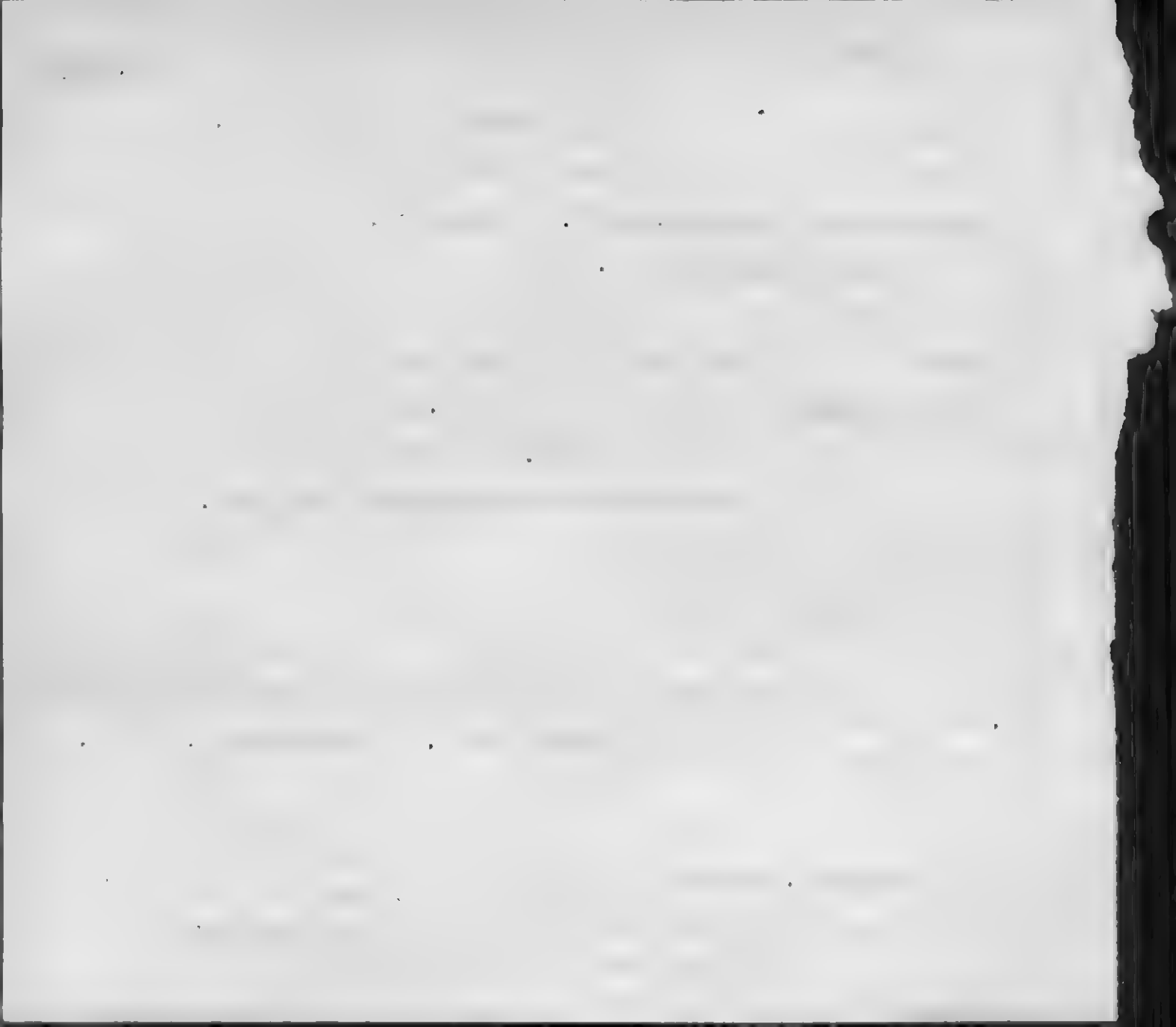
Md. MAY 10 '61

24b. REGISTRAR'S SIGNATURE

Charles S. Kinn

Page 5 may be released for you. Pages 1 and 2 with the State Board of Health, and in any event within 72 hours after death or its designated agent, prior to burial, cremation, or removal.

MEDICAL CERTIFICATION





5123

## CERTIFICATE OF DEATH

Reg. Dist. No. 05113

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <u>MD</u> c. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. Agnes Hospital</u>		d. STREET ADDRESS <u>Marble St.</u>	
3. NAME OF DECEASED (Type or print) <u>Laure</u> First <u>Jacobs</u> Middle <u>Marie</u> Last		4. DATE OF DEATH <u>May</u> Month <u>1961</u> Day <u>1</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar, 20 1876</u>
9. AGE (In years, last birthday) <u>85 yrs</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A. A. Co</u>
11. BIRTHPLACE (State or foreign country) <u>A. A. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>A</u>	
13. FATHER'S NAME <u>John H. Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Martha Bailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Helen Jacobs</u>		Address <u>Marble St. 8</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>arteriosclerosis</u> DUE TO (c) <u>con. arterio sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5y</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 1954</u> to <u>May 29, 1961</u> , that I last saw the deceased alive on <u>5-24-61</u> , and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter H. Hinkle</u> M.D.		ADDRESS (Street, city or town, state) <u>45 Franklin St. E-1-61</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>June 2/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Anne Arundel MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Johnson</u>		ADDRESS <u>Annapolis</u>	24a. REC'D BY REGISTRAR <u>June 5 '61</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4  
may be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



the attending physician and completely filled with the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

05114

5124

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Geo G. Meade</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>United States Army Hospital</u>				d. STREET ADDRESS <u>709 Park Ave Apt # 15</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>KAREN</u> Middle <u>MARIE</u> Last <u>JAHNCKE</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>6</u> Year <u>19 61</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>Cau</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 May 61</u>	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES H. JAHNCKE</u>				14. MOTHER'S MAIDEN NAME <u>M. ARLENE BURKEY</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>-</u>		16. SOCIAL SECURITY NO <u>-</u>		17. INFORMANT Address <u>Father 709 Park Ave Laurel, Md.</u>			
18 CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I INTERVAL BETWEEN ONSET AND DEATH <u>1</u>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour <u>a</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) _____ (County) _____ (State) _____	
21 I certify that (I) <del>(XXXXXX)</del> attended the deceased from <u>4 May</u> 19 <u>61</u> to _____ 19 _____ that (I) (we) last saw the deceased alive on <u>6 May</u> 19 <u>61</u> , and that death occurred at <u>9:30 PM</u> from the causes and on the date stated above							
22a SIGNATURE <u>Sherman S. Robinson</u>				22b DATE SIGNED <u>6 May 61</u>			
22c PHYSICIAN'S NAME (Type) <u>SHERMAN S. ROBINSON, Capt., M.C.</u>				22d ADDRESS <u>USA Hosp Ft Geo G. Meade, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City, town, or county) State	
<u>17/7/61</u>		<u>17/7/61</u>		<u>Summit Mountain</u>		<u>Laurel, Prince George's Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Robinson</u>				25a REC'D BY REGISTRAR DATE <u>7/7/61</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



## b. COUNTY

e IS RESIDENT  
ON A FARM  
YES ☐ NO ☒

Day 29th Year 10

IF UNDER 24 HR	
Hours	Min
0	00
1	00
2	00
3	00
4	00
5	00
6	00
7	00
8	00
9	00
10	00
11	00
12	00
13	00
14	00
15	00
16	00
17	00
18	00
19	00
20	00
21	00
22	00
23	00

12 CITIZEN OF WHAT COUNTRY?

Rosalie Jacobs

Same As #2

DUE TO

## INTERVAL BETWEEN ONSET AND DEATH

19 WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

{Stote}

DATE SIGNED \_\_\_\_\_

5/3/11

24b. REG STRAR'S SIGNATURE

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [redacted] the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05116

5126

**1. PLACE OF DEATH**  
 a. COUNTY Allegany **MARYLAND**  
 b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Uniontown  
 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park  
 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Severna Park 400  
 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**2. USUAL RESIDENCE** (Where deceased lived, if institution; Residence before admission)  
 a. STATE MD b. COUNTY AA  
 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park  
 d. STREET ADDRESS Severna Park 400  
 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print)  
 First James Middle F. Last Fleming  
**4. DATE OF DEATH**  
 Month 5 Day 24 Year 1961

**5. SEX** M **6. COLOR OR RACE** C **7. MARRIED** ☒ NEVER MARRIED ☐ **8. DATE OF BIRTH**  
 Month 4 Day 4 Year 23  
**9. AGE** (In years last birthday) 38 yrs **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)  
James F. Fleming  
**11. KIND OF BUSINESS OR INDUSTRY** Insurance  
**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME** James F. Fleming  
**14. MOTHER'S MAIDEN NAME** James F. Fleming  
**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no or unknown) (If yes give year or dates of service)  
Yes  
**16. CAUSE OF DEATH** (Enter only one cause per line for a, b, and c)  
 a. IMMEDIATE CAUSE (a) Uremia  
 b. DUE TO Chronic renal insufficiency  
 c. DUE TO Renal insufficiency  
 d. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Interval between onset and death  
**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** (If either, NOTIFY MEDICAL EXAMINER)  
**20b. DESCRIBE HOW INJURY OCCURRED** (Enter nature of injury in Part I or Part II of item 18)  
**20c. TIME OF INJURY** Hour 19 a.m. 5 p.m.  
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐  
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) 1957  
**20f. City or town** Severna Park **County** AA **State** MD

**21. I certify that** ( ) ( ) attended the deceased from 5-24-61 to 5-24-61, that (I) ( ) last saw the deceased alive on 5-23-61, and that death occurred at 4:00 A.M. M, from the causes and on the date stated above.  
**22a. SIGNATURE** Robert P. Fleming **22b. DATE SIGNED** 5/24/61  
**22c. PHYSICIAN'S NAME** (Type) Robert P. Fleming **22d. ADDRESS** Severna Park 400  
**23a. BURIAL, CREMATION, REMOVAL** (Specify) 12-23-61 **23b. DATE THEREOF** 12-23-61  
**23c. NAME OF CEMETERY OR CREMATORY** Greenwood **23d. LOCATION** (City, town or county) Severna Park (State) MD  
**24. FUNERAL DIRECTOR'S SIGNATURE** Arthur A. Thomas **ADDRESS** Annapolis  
**25a. REC'D BY REGISTRAR** MAY 26 '61 **25b. REGISTRAR'S SIGNATURE** Arthur A. Thomas

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

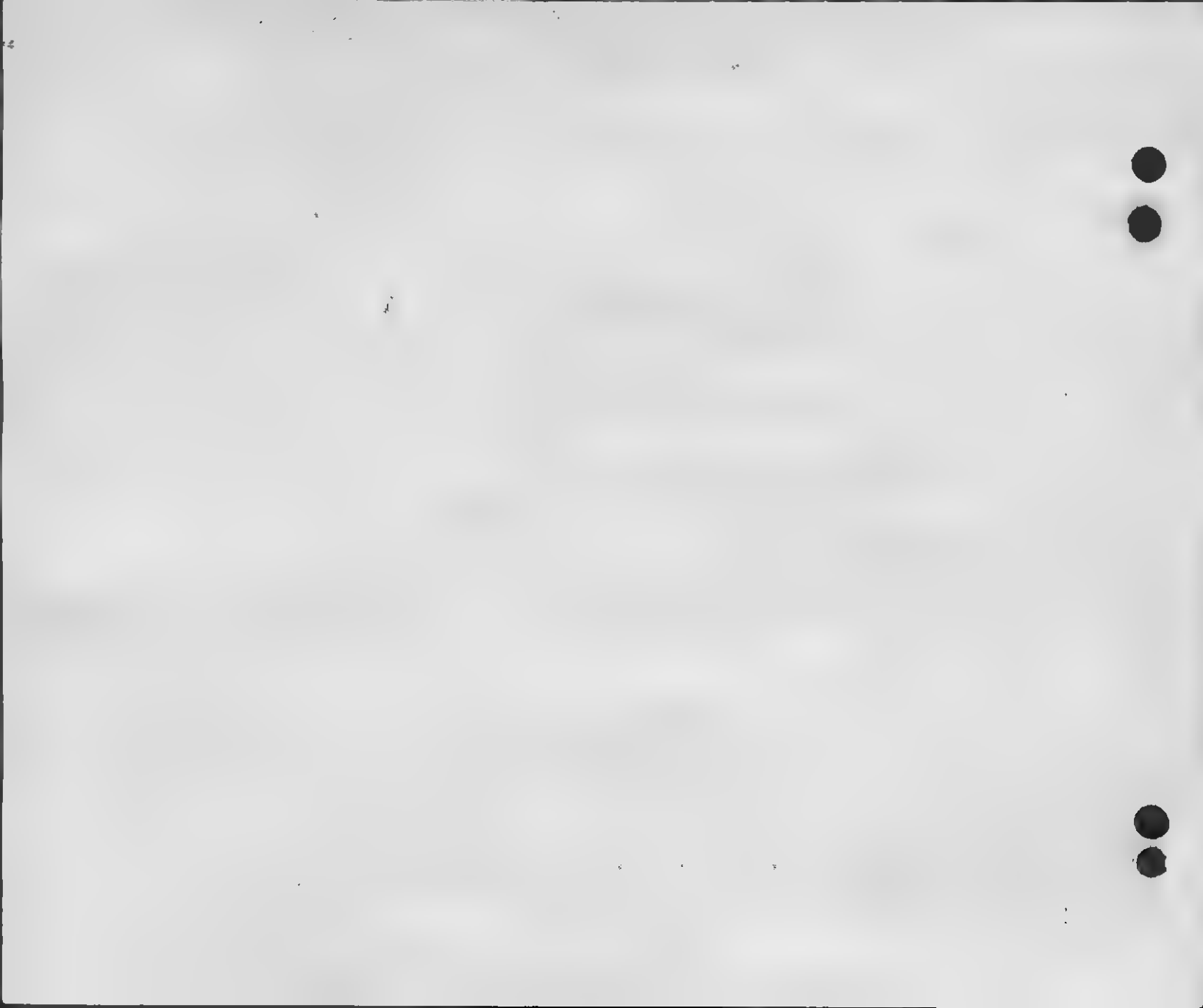
# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05117

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>621 Second St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BELINDA JOHNSON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> , Year <b>1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 4, 1961</b>	
9. AGE (In years last birthday) <b>4</b> yrs.		10. IF UNDER 1 YEAR: Months <b>4</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Linda Coffey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>621-111-1111</b>	
17. INFORMANT <b>Alexander Johnson</b>		Address <b>621 Second St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial Pneumonitis</b> <b>525X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>19</b> a.m. _____ p.m. _____ Month, Day, Year <b>1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5/15/61</b>	
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		Address (Street, city, town, or county) _____	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>5-16-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>	
22d. LOCATION (City, town, or county) <b>Annapolis</b>		22e. (State) <b>Md.</b>	
23. FUNERAL DIRECTOR <b>William H. Fisher</b>		24a. REC'D BY REGISTRAR <b>MAY 17 '61</b>	
ADDRESS <b>621 Second St.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fisher</b>	



5128

## CERTIFICATE OF DEATH

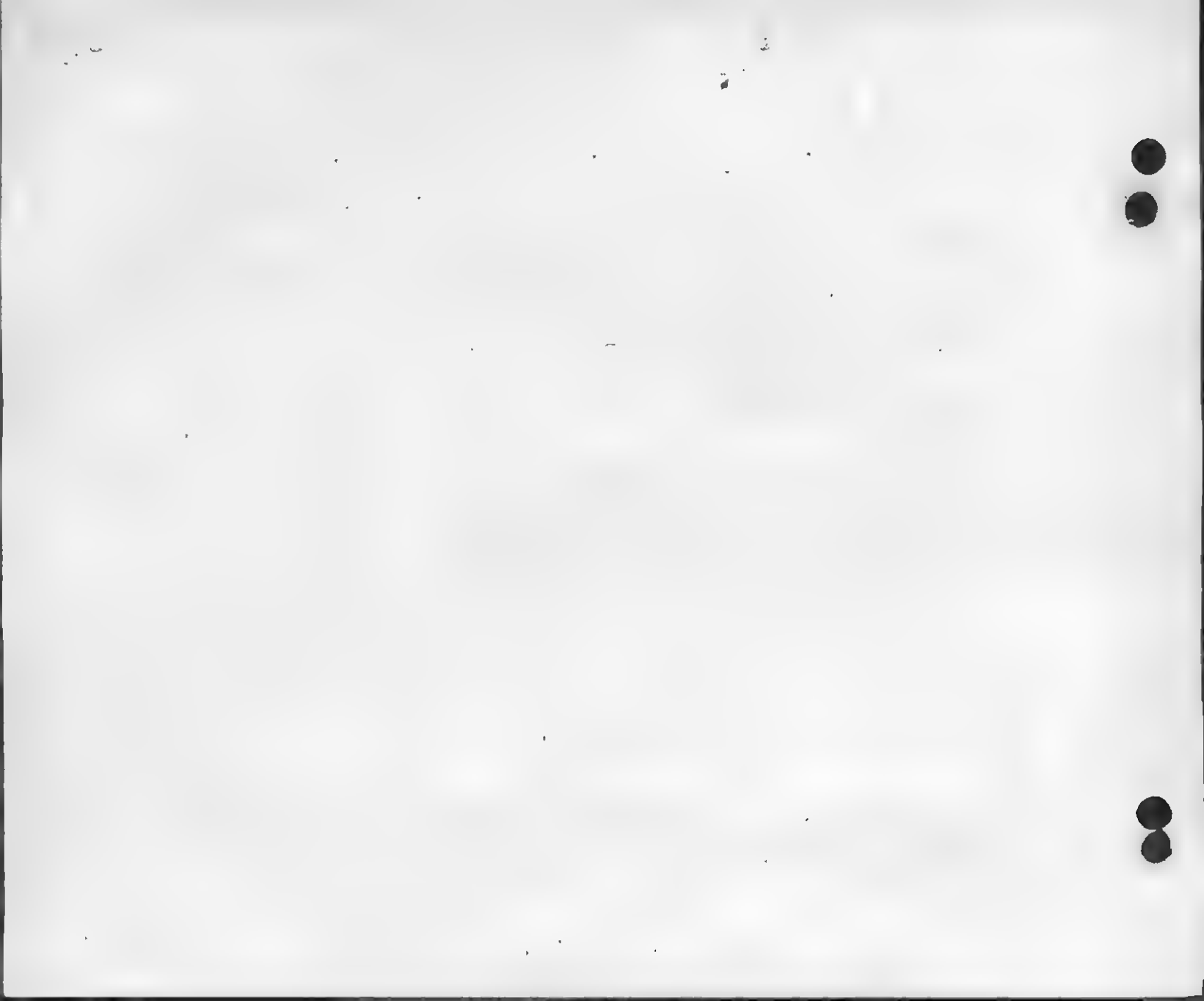
Reg. Dist. No.

05118

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Md.</b> c. LENGTH OF STAY N 1b <b>3 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>300 - 16th Street N.E.</b>	
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Lee</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1956</b>
9. AGE (In years last birthday) <b>4</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>		12. C.T. OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Leonard Leroy Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Shirley Stuckey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>INFORMANT</b> Address <b>Children's Center, Laurel, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Microcephaly</b> DUE TO <b>Mental Retardation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I; 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 14, 1958</b> to <b>May 19, 1961</b> , that I last saw the deceased alive on <b>May 19, 1961</b> , and that death occurred at <b>6:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Margaret W. Mola</b>		M.D. <b>Children's Center, Laurel, Md.</b> <b>5/19/61</b>	
PHYSICIAN'S NAME (Type) <b>Margaret W. Mola, M.D.</b>		<b>Children's Center, Laurel, Md.</b> <b>5/19/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>May 23, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>District Training School</b>	22d. LOCATION (City, town, or county) (State) <b>Laurel, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Honeys Jr</b>		24a. REC'D BY REGISTRAR <b>Children's Center</b> DATE <b>MAY 26 '61</b>	24b. REGISTRAR'S SIGNATURE <b>William S. Honeys</b>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5129

## CERTIFICATE OF DEATH

Reg. Dist. No. 65119

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived - If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>1019 Smithville Street</b>	
3. NAME OF DECEASED (Type or print) First <b>ISAACS</b> Middle <b>JOHNSON</b> Last <b>Jr.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12 - 1900</b>
9. AGE (In years last birthday) <b>60</b> yrs		10. IF UNDER 1 YEAR: Months <b>60</b> Days <b>60</b> Hours <b>60</b> Min <b>60</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook-U.S. Naval Hospital</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
12. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. FATHER'S NAME <b>ISAACS JOHNSON Sr.</b>		15. MOTHER'S MAIDEN NAME <b>BLANCHE STEPNEY</b>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. SOCIAL SECURITY NO. <b>Unknown</b>	
18. INFORMANT <b>ISAACS JOHNSON Sr.</b>		19. ADDRESS <b>414 Chesapeake Ave., Annapolis, Md.</b>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>72001</b> Conditions (any, which gave rise to immediate cause (a), stating the underlying cause lost) (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>-----</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <b>-----</b>			
21. INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
22. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
24a. TIME OF INJURY Month, Day, Year Hour <b>o</b> m. <b>19</b> p. m.	24b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	24d. (City or town) (County) (State)
25. I certify that I attended the deceased from <b>May 11, 1961</b> to <b>May 13, 1961</b> , that I last saw the deceased alive on <b>May 13, 1961</b> , and that death occurred at <b>1:20 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Therese H. Johnson MD</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>T.H. JOHNSON</b>		<b>Calvert Street Annapolis, Maryland</b>	
26a. BURIAL, CREMATION, REMOVAL (Specify)	26b. DATE THEREOF	26c. NAME OF CEMETERY OR CREMATORY	26d. LOCATION (City, town or county) (State)
<b>Burial</b>	<b>5-16-61</b>	<b>Brewer Hill</b>	<b>Annapolis, Maryland</b>
27. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. HICKS III</b>		28. ADDRESS <b>111 Annapolis, Maryland</b>	
29. REC'D BY REGISTRAR DATE <b>May 20 1961</b>		30. REGISTRAR'S SIGNATURE <b>Charles S. ...</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5130

05120

1 PLACE OF DEATH a. COUNTY <u>11 11</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If inst. fut. on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>11</u>	
b. CITY OR TOWN (If outside corporate limits, write "RURAL" and give nearest town) <u>11 11</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>11 11</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 11</u>		d. STREET ADDRESS <u>11 11</u>	
3 NAME OF DECEASED (Type or print) <u>William J. Johnson</u> First Middle Last		4 DATE OF DEATH Month <u>5</u> Day <u>16</u> Year <u>1961</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-5-18</u>
9 AGE (In years last birthday) <u>43</u> yrs		IF UNDER 1 YEAR: Months <u>1</u> Days <u>16</u> IF UNDER 24 HRS: Hours <u>8</u> Min <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>	
11 BIRTHPLACE (State, or foreign country) <u>Delaware</u>		12 CITIZEN OF WHAT COUNTRY? <u>A</u>	
13 FATHER'S NAME <u>William J. Johnson</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth B. Johnson</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>	
17 INFORMANT <u>Charles H. Johnson</u> Address <u>11 11</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Mitral insufficiency</u> DUE TO (c) <u>Hypertension</u> CONDITIONS (f any which gave rise to immediate cause (a), stating the underlying cause lost) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>None</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 months</u> <u>6 months</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour <u>8</u> a.m. <u>20</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21 I certify that (I) (this has to) attended the deceased from <u>August 1, 1960</u> to <u>May 16, 1961</u> that (I) (we) last saw the deceased alive on <u>May 16, 1961</u> , and that death occurred at <u>8:20 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodore H. Johnson</u>		22b. DATE SIGNED <u>May 18, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Theodore H. Johnson, M.D.</u>		22d. ADDRESS <u>37 Calvert St., Annapolis, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-21-61</u>		23b. NAME OF CEMETERY OR CREMATORY <u>Catharine</u>	
23c. LOCATION (City, town, or county) <u>Jethian</u>		23d. TO <u>11 11</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>11 11</u>		25a. REC'D BY REGISTRAR <u>11 11</u> 25b. REGISTRAR'S SIGNATURE <u>11 11</u>	
DATE <u>11 11</u>		DATE <u>11 11</u>	





## CERTIFICATE OF DEATH

Reg. Dist. No. 05121

1 PLACE OF DEATH a. COUNTY <u>AA. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institutional, give nearest town) b. STATE <u>md</u> c. COUNTY <u>AA. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patapsco Park</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>207 Midland Ave</u>		d. STREET ADDRESS <u>207 Midland Ave</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary S. Plater Jones</u>		4. DATE OF DEATH Month Day Year <u>May 21 1961</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24 1878</u>
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11 BIRTHPLACE (State or foreign country) <u>md</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Michael Worden</u>		14 MOTHER'S MAIDEN NAME <u>Imagyn Saunders</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Imagyn Saunders</u>		Address <u>1624 H. ...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Unk.</u> <u>Unk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 Apr 1949</u> to <u>21 May 1961</u> , that I last saw the deceased alive on <u>21 May 1961</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Renold B. Lightner</u>		ADDRESS (Street, city or town, state) <u>501 Cherry Hill Road</u>	
DATE SIGNED <u>May 23 1961</u>			
PHYSICIAN'S NAME (Type) <u>Renold B. Lightner Jr</u>		<u>Baltimore - 25 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-25-61</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Wheaton</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Nelson</u>		ADDRESS <u>1348 N. Calhoun St</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5132

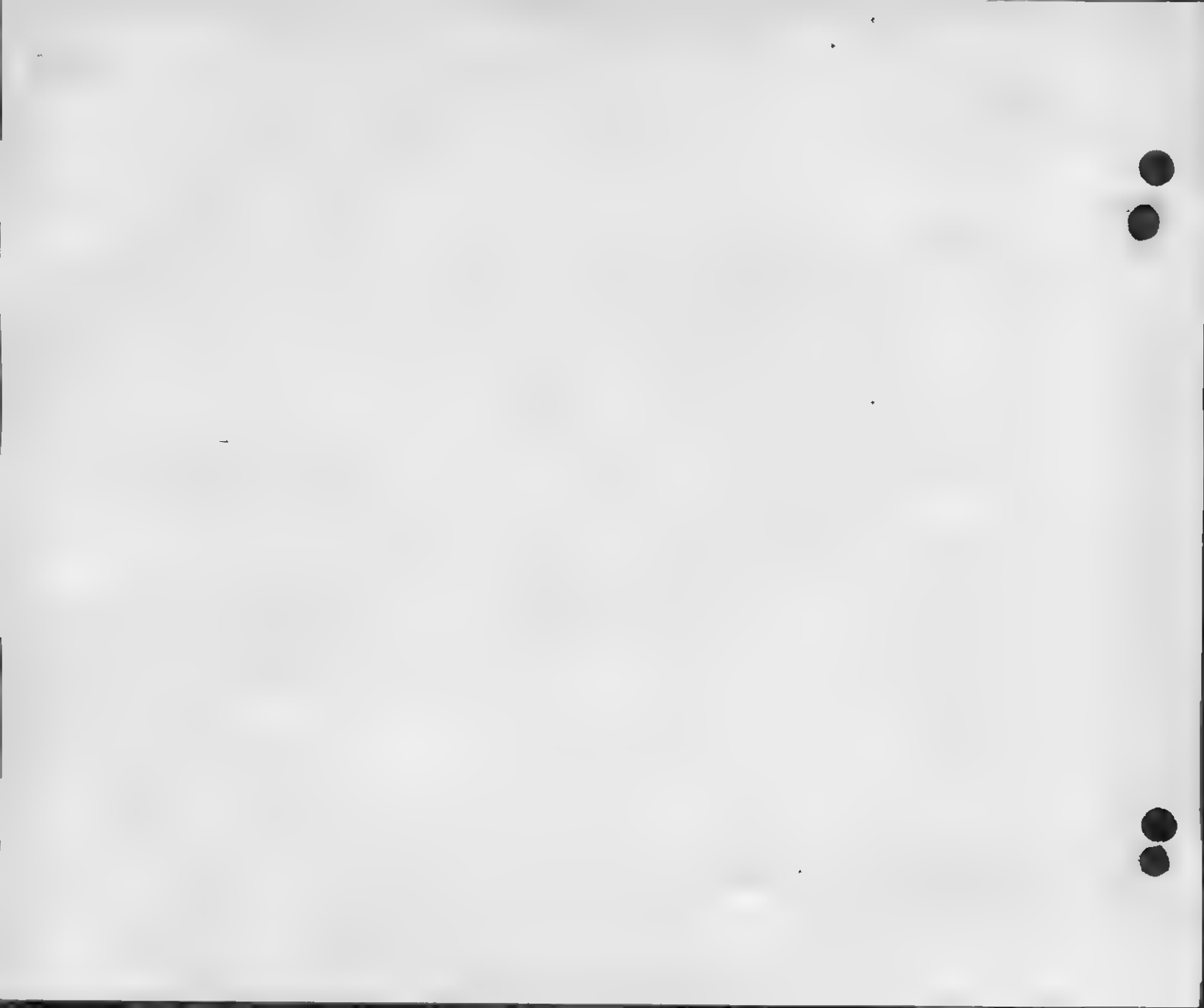
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

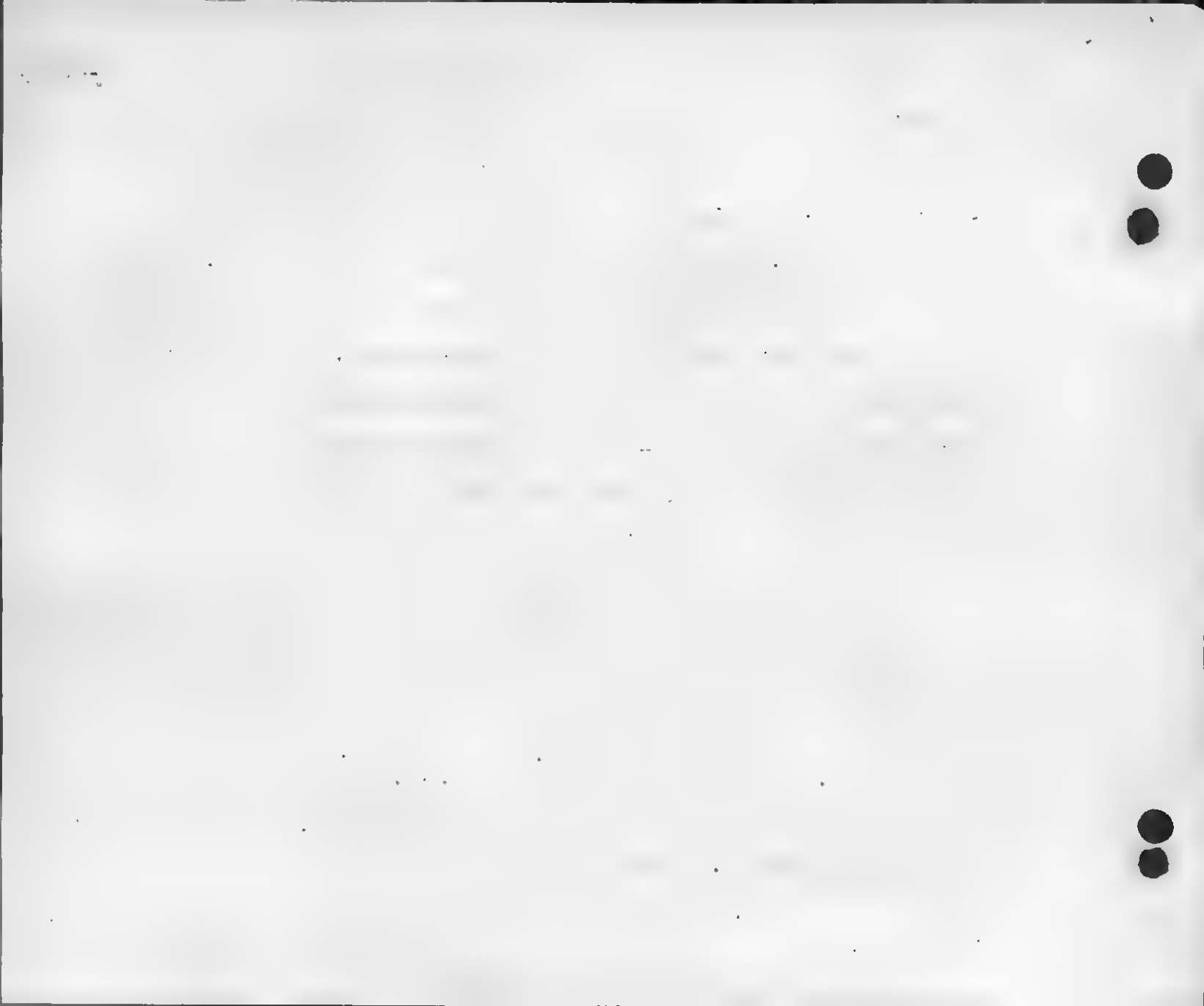
Reg. Dist. No. 05122

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>121 West Street</u>				d. STREET ADDRESS <u>121 West Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LAWRENCE</u> Middle <u>E</u> Last <u>KING</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1912</u>		9. AGE (In years last birthday) <u>49 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General repair</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph W. King</u>				14. MOTHER'S MAIDEN NAME <u>Matty E.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs Jane Louise Jones— Sister— same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>  </u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)				DATE SIGNED <u>5/26/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 27, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edwards Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 29 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see page 1 of this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5134

05124

1. PLACE OF DEATH  
a. COUNTY **Anne Arundel** MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Annapolis** 4 hours  
c. LENGTH OF STAY IN b. **4 hours**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Anne Arundel General Hospital**

2. USUAL RESIDENCE (Where deceased lived, if not in a. STATE **Maryland** b. COUNTY **Anne Arundel**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **RURAL - Millersville**  
d. STREET ADDRESS **P.O. Box-70**

3. NAME OF DECEASED (Type or print) **Mary** P. KOCUR **May** 4. DATE OF DEATH **May** 4 19 **61**  
5 SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **June 21, 1903** 9. AGE (In yrs. last birthday) **57** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs Hours Min.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **-** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **Anthony Struzykowski** 14. MOTHER'S MAIDEN NAME **Apolonia Dziadoszek**

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) **no** 16. SOCIAL SECURITY NO. **Mr. Leon Kocur, Route 3, Box 70, Millersville Md**  
17. INFORMANT **Mr. Leon Kocur, Route 3, Box 70, Millersville Md**

18. CAUSE OF DEATH (Enter only one cause)  
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE **X**  
DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS (TO THIS TIME) DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (b) YES ☐ NO ☒

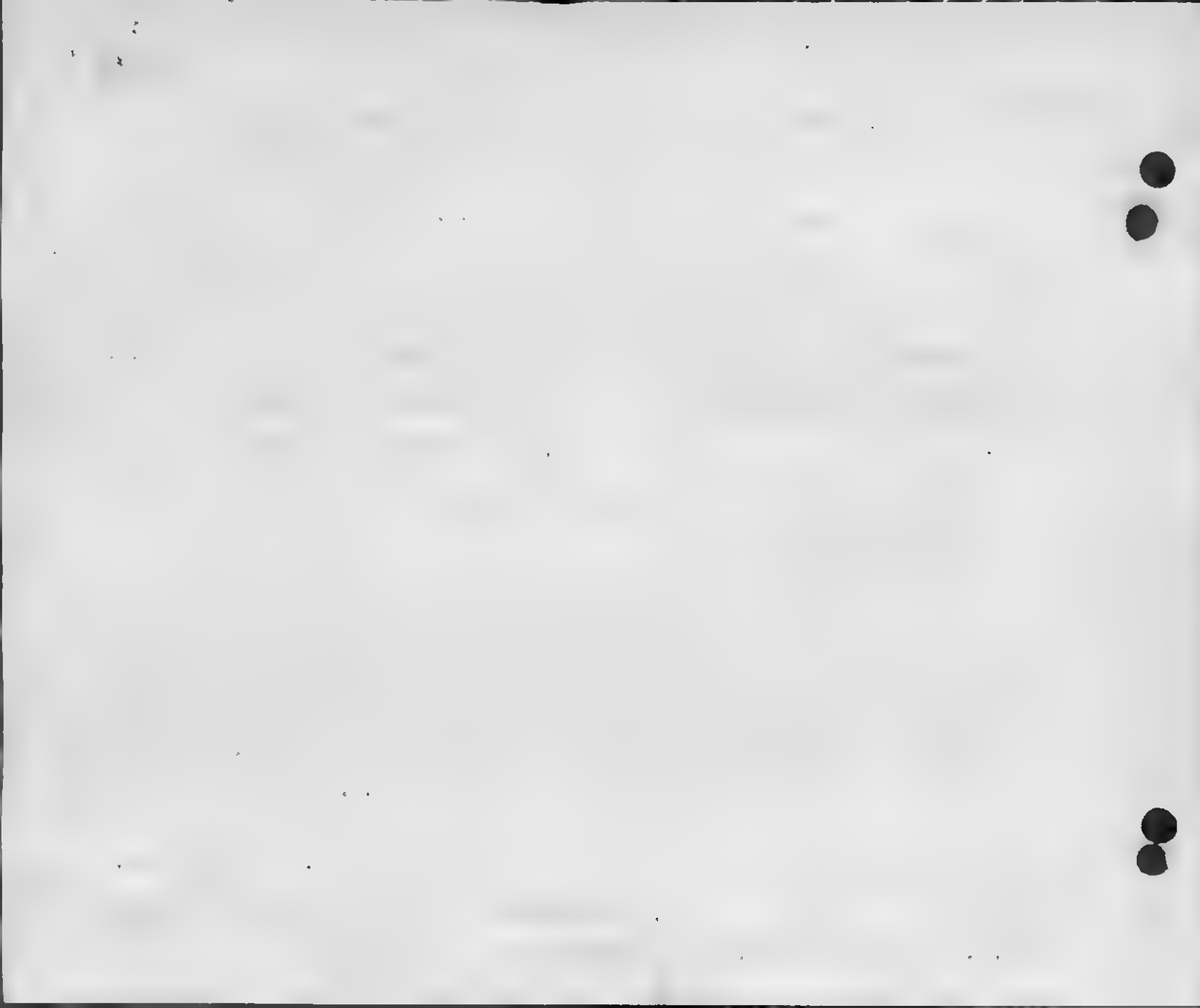
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Give nature of injury in Part I. Period of time)  
20c. TIME OF INJURY Month, Day, Yr **May 3, 1961** 20d. INJURY OCCURRED 21. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **121 Cathedral St., Annapolis, Md.**

21. I certify that **Richard N. Peeler** attended the deceased from **May 3, 1961** to **May 3, 1961** that (1) **xxx** last saw the deceased alive on **May 3, 1961** and that death occurred at **1:30 A.M.** from the causes and on the date stated above.  
22a. SIGNATURE **Richard N. Peeler** M.D. ATTENDING PHYSICIAN ☒ MED. DIRECTOR ☐ STAFF PHYSICIAN ☐  
22c. PHYSICIAN'S NAME (Type) **Richard N. Peeler** 22d. ADDRESS **121 Cathedral St., Annapolis, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **5/8/61** 23c. NAME OF CEMETERY OR CREMATORY **St. Stanislaus** 23d. LOCATION **Baltimore, Maryland**  
24. FUNERAL DIRECTOR'S SIGNATURE **M.F. SADOWSKI & SONS, 1808 EASTERN AVE** 25a. RECEIVED BY REGISTRAR **MAY 8 1961** 25b. REGISTRAR'S SIGNATURE **Carlton S. Thomas**

TO HOSPITAL: The law requires that the death certificate be executed with 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5135

## CERTIFICATE OF DEATH

Reg. Dist. No.

05125

1 PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Anne Arundel</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis (rural)</u>				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rural) Annapolis</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 2 Box 302</u>				d STREET ADDRESS <u>Rt. 2 Box 302</u>			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>M.</u> Last <u>Kuhn</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1961</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Jul. 11, 1876</u>	
9 AGE (in years last birthday) <u>84 yrs</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>				10b KIND OF BUSINESS OR INDUSTRY <u>  </u>		11 BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>  </u>							
13. FATHER'S NAME <u>Alvin Owings</u>				14. MOTHER'S MAIDEN NAME <u>Margery Plummer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16 SOCIAL SECURITY NO. <u>  </u>			
INFORMANT <u>Mrs. Margaret Kuhn</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>  </u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>(Unknown)</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>				20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, bag, etc.) <u>  </u>	
20f (City or town) <u>  </u>				20g (County) <u>  </u>		20h (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Sept. 1958</u> to <u>May 18, 1961</u> that I last saw the deceased alive on <u>April 30, 1961</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>P.O. Box 289 Severna Park, Maryland</u> DATE SIGNED <u>May 18, 1961</u>							
ACTUAL SIGNATURE <u>Francis I. Codd</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Francis I. Codd, M.D.</u>							
22a BURIAL, CREMATION, REMOVAL (Specify)		22b DATE THEREOF		22c NAME OF CEMETERY OR CREMATORY		22d LOCATION (City, town, or county) (State)	
<u>  </u>		<u>  </u>		<u>  </u>		<u>  </u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>  </u>				ADDRESS <u>  </u>		24a REC'D BY REG. STRAR DATE <u>May 20, 1961</u>	
						24b REG. STRAR'S SIGNATURE <u>  </u>	

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 05128

1 PLACE OF DEATH a. COUNTY <u>2.2.1.1</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lansdale</u> Last <u>Lansdale</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1961</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-24-82</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11 BIRTHPLACE (State or foreign country) <u>Tridolphus Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>THOS. FRANKLIN LANSDALE</u>		14 MOTHER'S MAIDEN NAME <u>ELIZA STRAIN</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>Yes</u>		16 SOC. A. SECURITY NO. <u>1-1-1-1</u>	
17 INFORMANT <u>John Lansdale Jr</u>		Address <u>Cleveland Ohio</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pulmonary edema</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Emily H. Wilson</u> M.D. <u>Lothian</u> <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify, <u>burial</u> )	22b. DATE THEREOF <u>1961</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
23 FUNERAL DIRECTOR'S SIGNATURE <u>James H. Wilson</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 2 1961</u>	24b. REGISTRAR'S SIGNATURE <u>Carl P. Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be used for hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5137

## CERTIFICATE OF DEATH

Reg. Dist. No.

15127

1. PLACE OF DEATH a. COUNTY <u>18</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>18</u> <b>MARYLAND</b> b. COUNTY <u>18</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18</u>		c. LENGTH OF STAY IN 1b <u>18</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>18</u>		e. STREET ADDRESS <u>18</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>18</u>		4. DATE OF DEATH Month Day Year <u>18</u>	
5. SEX <u>18</u>	6. COLOR OR RACE <u>18</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1894-66</u>
9. AGE (in years last birthday) <u>18</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>18</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>18</u>	
11. BIRTHPLACE (State or foreign country) <u>18</u>		12. CITIZEN OF WHAT COUNTRY? <u>18</u>	
13. FATHER'S NAME <u>18</u>		14. MOTHER'S MAIDEN NAME <u>18</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>18</u>		16. SOCIAL SECURITY NO. <u>18</u>	
17. INFORMANT <u>18</u>		Address <u>18</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>18</u> DUE TO <u>18</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>18</u> (b) <u>18</u> DUE TO <u>18</u> (c) <u>18</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>18</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>18</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>18</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>18</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>18</u> to <u>18</u> , that I last saw the deceased alive on <u>18</u> , and that death occurred at <u>18</u> M., from the causes and on the date stated above			
ACTUAL SIGNATURE <u>18</u>		DATE SIGNED <u>18</u>	
PHYSICIAN'S NAME (Type) <u>18</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>18</u>	22b. DATE THEREOF <u>18</u>	22c. NAME OF CEMETERY OR CREMATORY <u>18</u>	22d. LOCATION (City, town, or county) (State) <u>18</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>18</u>		24a. REC'D BY REGISTRAR <u>18</u>	
ADDRESS <u>18</u>		24b. REGISTRAR'S SIGNATURE <u>18</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
hours after  
death.  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**5138** **05128**

1. PLACE OF DEATH.  
a. COUNTY **Anne Arundle** **MARYLAND**  
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) **Annapolis Md** c. LENGTH OF STAY IN b. **1 day**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Annapolis Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution, give name)  
a. STATE **Maryland** b. COUNTY **Anne Arundle**  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Glen Isle Beach**  
d. STREET ADDRESS **Riva, Md**

3. NAME OF DECEASED (Type or print)  
First **George** Middle **E.** Last **Long**

4. DATE OF DEATH  
Month **May** Day **28** Year **1961**

5. SEX **male** 6. COLOR OR RACE **white** 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH  
WIDOWED ☐ DIVORCED ☐ **Feb 28, 1890**

9. AGE (In years last birthday) **71** yrs. IF UNDER 1 YEAR: Months, Days, Hours, Minutes

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired, self) **Retired Bricklayer** 10b. KIND OF BUSINESS OR INDUSTRY **Washington D C** 12. CITIZEN OF WHAT COUNTRY? **U S A**

13. FATHER'S NAME **Jacob A Long** 14. MOTHER'S MAIDEN NAME **Mary E unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) **yes 1920-1921** 16. SOCIAL SECURITY NO. **1920-1921** 17. INFORMANT Address **Elizabeth C. Long Riva, Md.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **4-11** DUE TO **Heart failure**  
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last **11** DUE TO **11**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. **SC**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. A DISEASE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

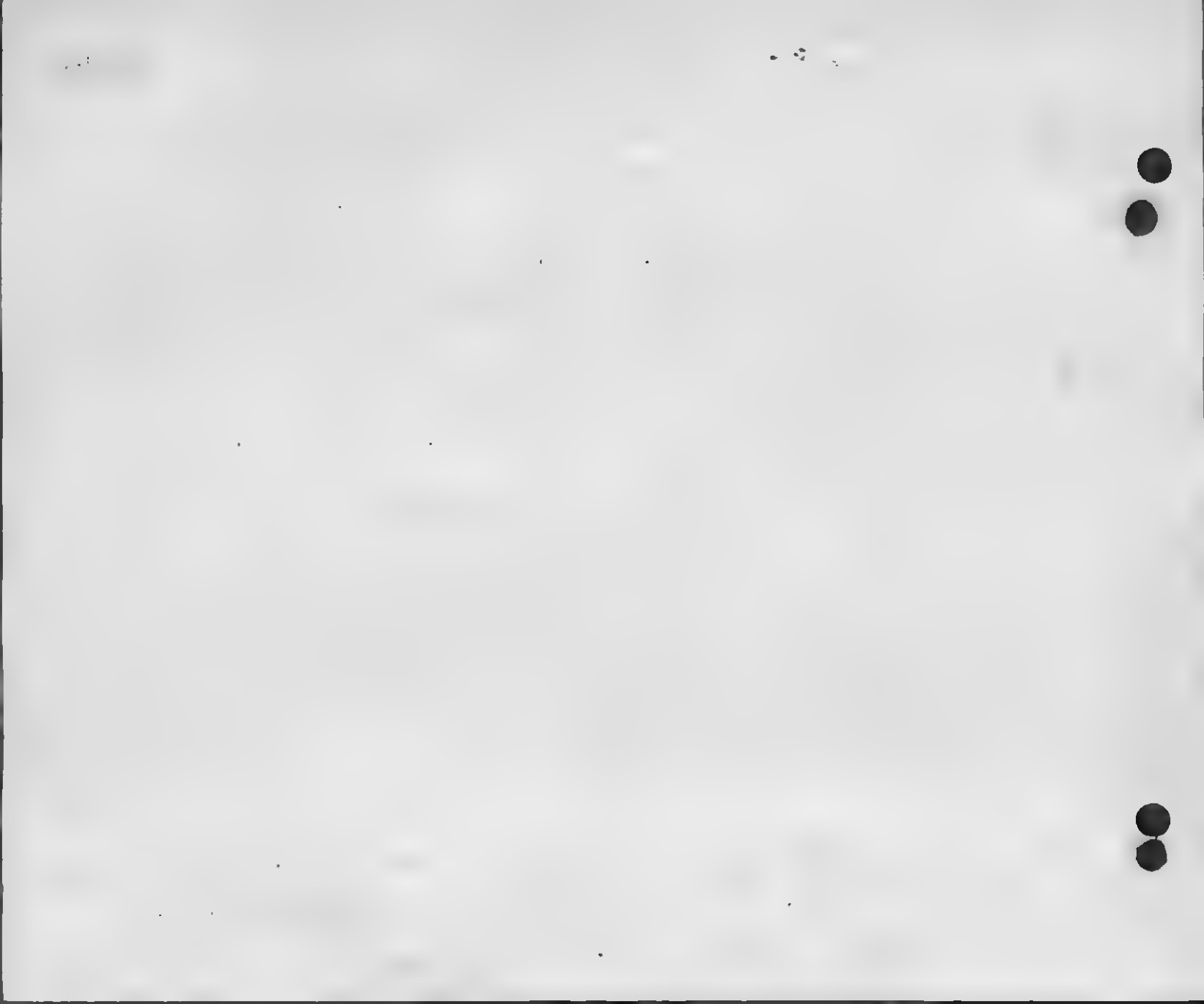
21. I certify that (I) (this hospital) attended the deceased from **2** to **2**, 19**61**, that (I) (we) last saw the deceased alive on **2** 19**61**, and that death occurred at **Md**, from the causes and on the date stated above

22. SIGNATURE **Edith Rodler** ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ DATE **May 28, 1961**

22c. PHYSICIAN'S NAME (Type) **Edith Rodler** 22d. ADDRESS **Annapolis Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **May 31, 1961** 23c. NAME OF CEMETERY OR CREMATORY **Ft Lincoln Cemetery** 23d. LOCATION (City, town or county, State) **Colmar Manor, Md.**

24. FUNERAL DIRECTOR'S SIGNATURE **F. Gasch's Sons** ADDRESS **Hyattsville, Md.** 25a. RECD BY REGISTRAR **MAY 31 '61** 25b. REGISTRAR'S SIGNATURE **J. H. H.**





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5139

05129

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis  
c. LENGTH OF STAY IN 2 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital  
e. STATE Maryland  
f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Severn  
g. STREET ADDRESS Box-342, Old Quarterfield Road  
h. IS RESIDENCE ON A FARM? YES ☐ NO ☒  
3. NAME OF DECEASED (Type or print) Gilbert LOWMAN  
4. DATE OF DEATH May 4 1961  
5. SEX Male  
6. COLOR OR RACE White  
7. MARRIED ☒ NEVER MARRIED ☐  
8. DATE OF BIRTH June 19, 1896  
9. AGE (in yrs. - mos. - days) 64 yrs. 184 mos. 4 days  
10. USUAL OCCUPATION (give kind of work done during most of working life, even if retired) Chauffeur  
11. KIND OF BUSINESS OR INDUSTRY Maryland  
12. CITIZEN OF WHAT COUNTRY? U.S.  
13. FATHER'S NAME Wm Lowman  
14. MOTHER'S MAIDEN NAME UNK.  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ☐  
16. SOCIAL SECURITY NO. MRS Charlotte Lowman, same as 2  
17. INFORMANT MRS Charlotte Lowman, same as 2  
Address

1. CAUSE OF DEATH (Enter on only one column)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Myocardial Infarction  
DUE TO (b) (in hospital)  
c. (e), stating the underlying cause last. (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I)  
Coronary Artery Disease  
20a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
21. I certify that (I) Dr. Maurice Klawans attended the deceased from May 4, 1961 to May 4, 1961 that (I) XX saw the deceased alive on May 4, 1961 and that death occurred at 10:30 P.M. from the causes and on the date stated above  
22a. SIGNATURE Maurice Klawans M.D.  
22b. ADDRESS 31 Southgate Ave., Annapolis, Md.  
22c. PHYSICIAN'S NAME (Type)  
22d. ADDRESS

20c. TIME OF INJURY Month Day Year May 4 1961  
20d. INJURY OCCURRED While at work  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. City or town Annapolis County Anne Arundel State Md.  
21. I certify that (I) Dr. Maurice Klawans attended the deceased from May 4, 1961 to May 4, 1961 that (I) XX saw the deceased alive on May 4, 1961 and that death occurred at 10:30 P.M. from the causes and on the date stated above  
22a. SIGNATURE Maurice Klawans M.D.  
22b. ADDRESS 31 Southgate Ave., Annapolis, Md.  
22c. PHYSICIAN'S NAME (Type)  
22d. ADDRESS  
23a. BURIAL CREMATION BURIAL  
23b. DATE THEREOF 5-8-61  
23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cem.  
23d. LOCATION (City, town or county) Baltimore Md  
24a. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kierthley  
24b. REC'D BY REG. STRAR May 9 '61  
24c. REGISTRAR'S SIGNATURE Charles L. Krawns

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 72 hours after death. The certificate is to be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)  
ISM 9/59

1

5141

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05131

1 PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Buenie, Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buenie, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buenie, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS <u>1111</u>	
3 NAME OF DECEASED (Type or print) <u>Lily M. Mearns</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-1905</u>
9. AGE (In years lost birthday) <u>55</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stephen Mearns</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mearns</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>1-1-1-1-1-1-1-1-1-1</u>	
17. INFORMANT <u>Arthur S. Kincaid</u>		Address <u>1111</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>433.1</u> DUE TO <u>Auricular</u>			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <u>14. Medial Damage</u> DUE TO <u>14. Medial Damage</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-15-1961</u> to <u>5-7-1961</u> , that (I) (we) last saw the deceased alive on <u>5-7-1961</u> and that death occurred on <u>5-7-1961</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur S. Kincaid</u>		22b. DATE SIGNED <u>5-7-1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur S. Kincaid</u>		22d. ADDRESS <u>Buenie</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-7-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>5024 Ritchie Hwy. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kincaid</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kincaid</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>		DATE <u>MAY 4 '61</u>	



VS. A15ME  
5M 7/59

24b. REGISTRAR'S SIGNATURE

19 WAS TOPSY  
PERFORMED?  
YES NO ☒

24b. REGISTRAR'S SIGNATURE

24b. REGISTRAR'S SIGNATURE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5143

05133

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN <b>Cedar Hill</b> c. LENGTH OF STAY <b>N 1b</b>		2. USUAL RESIDENCE (Where dec. died and lived. If still there, Res. on date of death) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If out of corporate limits, write RURAL) <b>Cedar Hill</b> d. STREET ADDRESS <b>308 Snow Hill Road - #25</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>308 Snow Hill Road</b>		4. DATE OF DEATH <b>May 28 1961</b>	
3. NAME OF DECEASED (Type or print) <b>Margery L. Mitchell</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>Colored</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>April 20, 1887</b> 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday. Month Days Hour Min) <b>74 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b> 11. BIRTH PLACE <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Richard T. Williams</b> 14. MOTHER'S MAIDEN NAME <b>Sarah J. Henson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>215-07-9649</b> 17. INFORMANT <b>Luvinia Hall - 306 Snow Hill Road</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE DUE TO <b>Coronary Occlusion</b> DUE TO <b>Broncho-genic Carcinomata &amp; Metastases</b> DUE TO <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)		20c. TIME OF INJURY Month, Day, Year <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>100 Cherry Lane, Glen Burnie, Md.</b> 20f. City or town <b>Baltimore</b> County <b>Baltimore</b> State <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2-10-1961</b> to <b>5-28-1961</b> that (I) (we) last saw the deceased alive on <b>5-28-1961</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard H. Hunt</b> 22c. PHYSICIAN'S NAME (Type) <b>RICHARD H. HUNT</b>		22b. DATE SIGNED <b>5-29-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>6-1-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b> 23d. LOCATION (City, town or county) <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b> ADDRESS <b>802 Madison Ave. Baltimore, Md.</b> 25a. REC'D BY REGISTRAR <b>MAY 3 '61</b> 25b. REGISTRAR'S SIGNATURE <b>W. J. R. Hunt</b>	



COUNTY Anne Arundel

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒

19 51

Hours	Min
-------	-----

US A

Marv Anna Gates

Mr John F. Mitchell- Son- same as # 2

(c)

PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 11(a)

19 WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

(150)

ADDRESS (Street, city or town, state)

DATE SIGNED \_\_\_\_\_

... 10044-1/2 ...

Edward S. Beck MD

7/ Franklin Street, Annapolis, Maryland

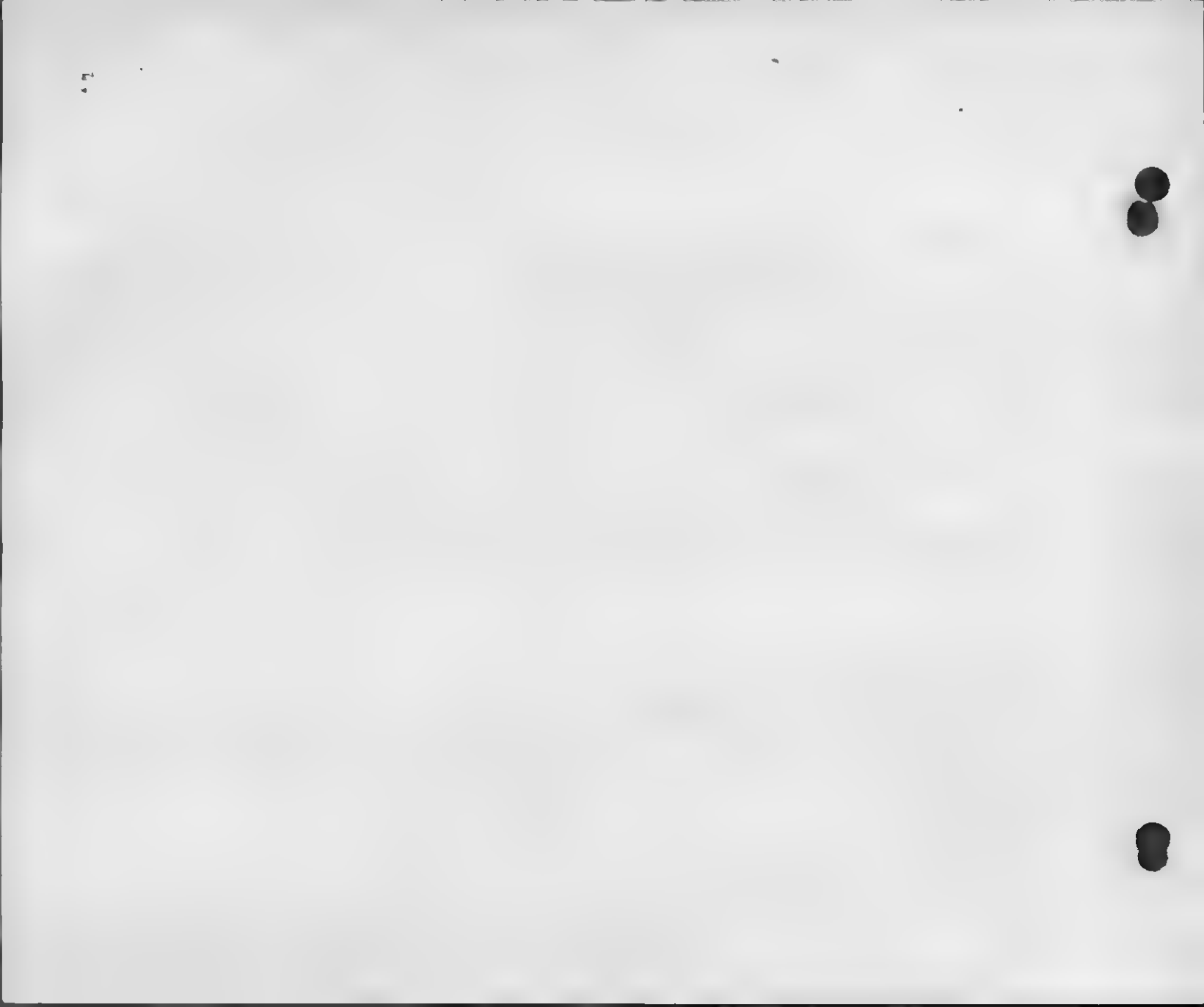
(Stole)

24b REGISTRAR'S SIGNATURE

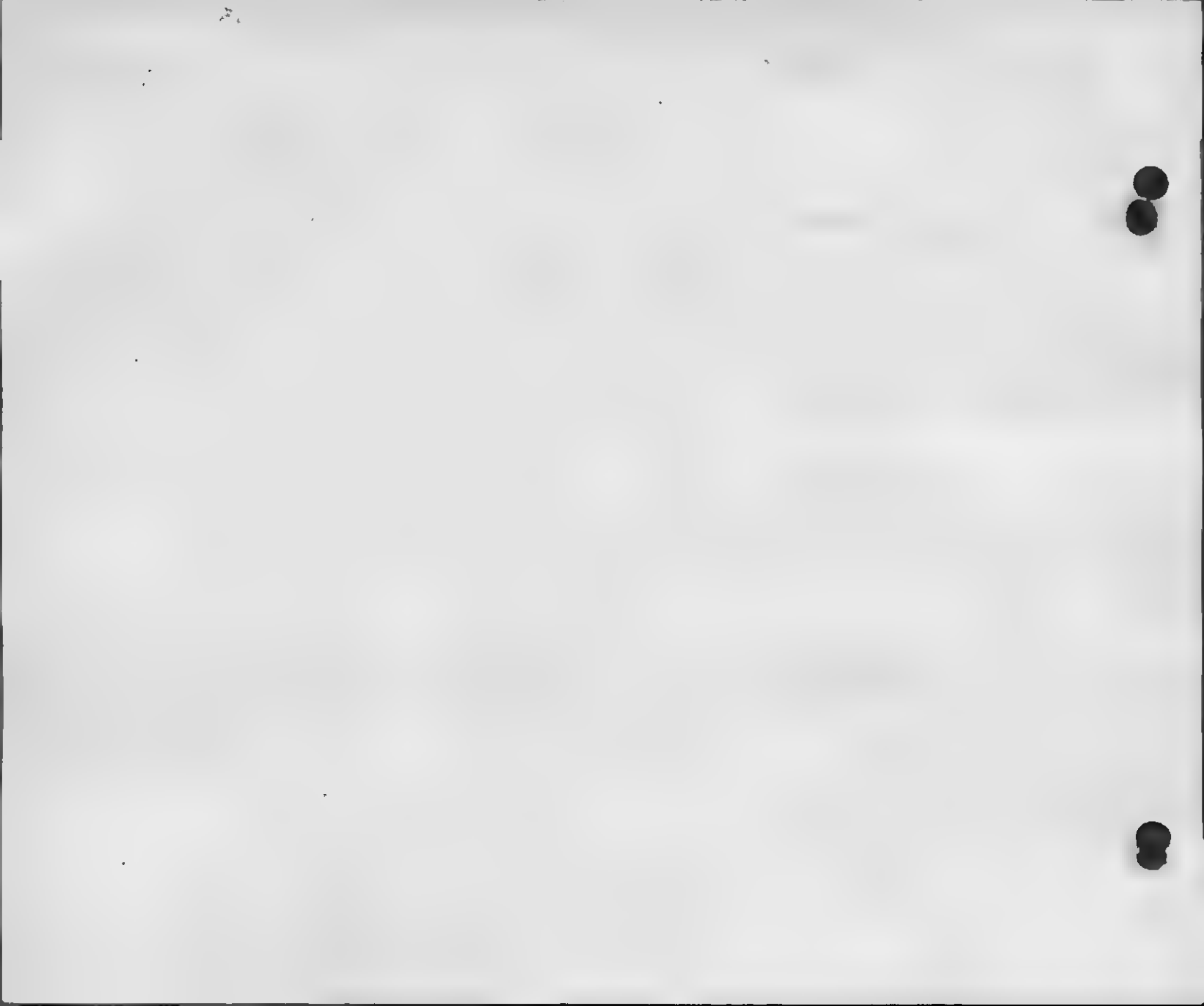
DATE MAY 29 '6

Christina &amp; Thomas

VS A15 (4)  
15M 10/57







# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05136

1146

PLACED BY THE

Anne Arundel

MARYLAND

2. USUAL RESIDENCE Where deceased lived, institution, etc. (a) STATE (b) COUNTY (c) CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Maryland

b. COUNTY

Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN

15 days

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Glen Burnie

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Anne Arundel General Hospital

d. STREET ADDRESS

604 Stewart Ave.,

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Mid

Last

DATE OF DEATH

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

Sept. 16, 1885

9. AGE (In years, if under 1 year, in months, days, hours, minutes)

75 yrs.

May 9, 1961

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FIRERIST

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (Country & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Thomas

Nevin

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

THOMAS NEVIN, Same as 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

CEREBRAL THROMBOSIS

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Not related to the terminal disease and condition given in Part I)

DIABETES MELLITUS, DIABETIC GANGRENE

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or attach statement)

20c. TIME OF INJURY (Month, Day, Year, Hour, a.m., p.m.)

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

County

(State)

21. I certify that ~~XXXXXX~~ attended the deceased from April 24, 1961, to May 8, 1961, and that death occurred at 2:40 A.M. from the causes and on the date stated above.

22. SIGNATURE

Edward S. Beck

ATTENDING PHYS.

22b. DATE

5/9/61

22. NAME (Type)

Edward S. Beck

22d. ADDRESS

71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL, SPECIFY

BURIAL

5-12-61

23c. NAME OF CEMETERY OR CREMATORY

Glen Haven

23d. LOCATION (City, town or county)

Glen Burnie

(State)

Md

24. FUNERAL DIRECTOR'S SIGNATURE

Hopping & Firkin, Glen Burnie

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE MAY 12, 1961

James S. Thomas

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If an autopsy is performed, page 3 should be detached for use as the burial-transit permit. If an autopsy is performed, page 3 should be detached for use as the burial-transit permit. If an autopsy is performed, page 3 should be detached for use as the burial-transit permit.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Give Page 4 to the funeral home. Give Page 5 to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your use. Give Page 6 to the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A1SME(S)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 5-37

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSONVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSONVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>DARVELL</u> Last <u>O'DELL</u>		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-28-1941</u>
9. AGE (In years last birthday) <u>20</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>ROBERT O'DELL</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ROBERT O'DELL</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Lombard</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Lombard</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-9-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons, Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5-11-61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. H. H.</u>	

DATE SIGNED

5/7/61



TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05138

1. PLACE OF DEATH a. COUNTY <u>A A</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE Where deceased lived, if institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNIE RET ANNUALE PHIPPS</u>		4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>May 18 1903</u>		9. AGE (in years last birthday) <u>57</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. PLACE OF BIRTH <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Wife</u> Address	
18. CAUSE OF DEATH (Enter only one cause, primary cause, b and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>Congestive heart failure</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (Optional - Give in Part II) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter in Part I or Part II, as applicable) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		INTERVIEW BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>		19. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (Ifs hospital) attended the deceased from <u>Feb. 1950</u> to <u>18 May 1961</u> , that (I) (we) last saw the deceased alive on <u>16 May 1961</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above		22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>May 20 1961</u>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town or county)		23e. LOCATION (City, town or county)		23f. LOCATION (City, town or county)	
24. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
24c. ADDRESS		DATE <u>JUN 2 '61</u>		<u>Charles S. Thomas</u>	

3

2 4 5



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 05132

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If first listed, residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>121 Faragut Rd.</u>		d. STREET ADDRESS <u>121 Faragut Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>OWEN FREDERICK PHIPPS</u>		4. DATE OF DEATH <u>May 9, 1961</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 1, 1910</u>
9 AGE (In years last birthday) <u>50 yrs</u>		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beverage Company</u>	
11 BIRTHPLACE (State or foreign country) <u>A.A. County, Maryland</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>Walter Phipps</u>		14 MOTHER'S MAIDEN NAME <u>Maude McCoy</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214 05 1359</u>	
17 INFORMANT <u>Mrs Ethel Virle Phipps- Wife- same as # 2</u>		Address <u>  </u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <u>  </u> (b) <u>On miscellaneous C.V. disease</u> DUE TO <u>  </u> (c) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years (2)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year <u>  </u> Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>May 8, 1961</u> to <u>May 9, 1961</u> , that I last saw the deceased alive on <u>May 8, 1961</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Maurice F. Klewans, MD</u>		ADDRESS (Street, city or town, state) <u>31 Southgate Ave., Annapolis, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Maurice F. Klewans MD</u>		DATE SIGNED <u>5/16/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 11, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>All Hallows</u>		22d. LOCATION (City town or county) <u>Birdsville, Maryland</u> (State) <u>  </u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Hopkins Funeral Home</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5150

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05140

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND  
b. CITY OR TOWN if outside corporate limits, write RURAL and give nearest town Annapolis  
c. LENGTH OF STAY IN 1b 4 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Res.)  
a. STATE Maryland b. COUNTY Anne Arundel  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis  
d. STREET ADDRESS Rt-1, Box-68

3. NAME OF DECEASED  
First Middle Last  
CHARLES FRANK PRENTISS  
4. DATE OF DEATH May 29 1961  
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐  
8. AGE in yrs at birthday 64 yrs 9. AGE in mos if under 1 yr 10. HRS. 11. MIN. 12. SEC. 13. MONTH 14. DAY 15. YEAR 16. MONTH 17. DAY 18. YEAR 19. MONTH 20. DAY 21. YEAR 22. MONTH 23. DAY 24. YEAR 25. MONTH 26. DAY 27. YEAR 28. MONTH 29. DAY 30. YEAR 31. MONTH 32. DAY 33. YEAR 34. MONTH 35. DAY 36. YEAR 37. MONTH 38. DAY 39. YEAR 40. MONTH 41. DAY 42. YEAR 43. MONTH 44. DAY 45. YEAR 46. MONTH 47. DAY 48. YEAR 49. MONTH 50. DAY 51. YEAR 52. MONTH 53. DAY 54. YEAR 55. MONTH 56. DAY 57. YEAR 58. MONTH 59. DAY 60. YEAR 61. MONTH 62. DAY 63. YEAR 64. MONTH 65. DAY 66. YEAR 67. MONTH 68. DAY 69. YEAR 70. MONTH 71. DAY 72. YEAR 73. MONTH 74. DAY 75. YEAR 76. MONTH 77. DAY 78. YEAR 79. MONTH 80. DAY 81. YEAR 82. MONTH 83. DAY 84. YEAR 85. MONTH 86. DAY 87. YEAR 88. MONTH 89. DAY 90. YEAR 91. MONTH 92. DAY 93. YEAR 94. MONTH 95. DAY 96. YEAR 97. MONTH 98. DAY 99. YEAR 100. MONTH 101. DAY 102. YEAR 103. MONTH 104. DAY 105. YEAR 106. MONTH 107. DAY 108. YEAR 109. MONTH 110. DAY 111. YEAR 112. 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MONTH 608. DAY 609. YEAR 610. MONTH 611. DAY 612. YEAR 613. MONTH 614. DAY 615. YEAR 616. MONTH 617. DAY 618. YEAR 619. MONTH 620. DAY 621. YEAR 622. MONTH 623. DAY 624. YEAR 625. MONTH 626. DAY 627. YEAR 628. MONTH 629. DAY 630. YEAR 631. MONTH 632. DAY 633. YEAR 634. MONTH 635. DAY 636. YEAR 637. MONTH 638. DAY 639. YEAR 640. MONTH 641. DAY 642. YEAR 643. MONTH 644. DAY 645. YEAR 646. MONTH 647. DAY 648. YEAR 649. MONTH 650. DAY 651. YEAR 652. MONTH 653. DAY 654. YEAR 655. MONTH 656. DAY 657. YEAR 658. MONTH 659. DAY 660. YEAR 661. MONTH 662. DAY 663. YEAR 664. MONTH 665. DAY 666. YEAR 667. MONTH 668. DAY 669. YEAR 670. MONTH 671. DAY 672. YEAR 673. MONTH 674. DAY 675. YEAR 676. MONTH 677. DAY 678. YEAR 679. MONTH 680. DAY 681. YEAR 682. MONTH 683. DAY 684. YEAR 685. MONTH 686. DAY 687. YEAR 688. MONTH 689. DAY 690. YEAR 691. MONTH 692. DAY 693. YEAR 694. MONTH 695. DAY 696. YEAR 697. MONTH 698. DAY 699. YEAR 700. MONTH 701. DAY 702. YEAR 703. MONTH 704. DAY 705. YEAR 706. 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FOR STATE  
HEALTH DEPT.

NECESSARY, IF A  
SCOR, PAGE  
FOR YOUR FILE  
M  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5151

1. PLACE OF DEATH  
a. COUNTY M.A. Co. b. CITY OR TOWN Rural-Annapolis c. LENGTH OF STAY IN b. 1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. ANNE ARUNDEL GENERAL

2. USUAL RESIDENCE (Where deceased lived, if not in institution, give street address)  
a. STATE M.D. b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamstonburg d. STREET ADDRESS

3. NAME OF DECEASED (Type or print) Richard L. Ratcliffe 4. DATE OF DEATH 5 7 1961

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 3-19-46 9. AGE (In years, last birthday) 21 yrs. 10. IF UNDER 18, R 1. Months 2. Days 3. Hours 4. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Easton, Md. 11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Richard L. Ratcliffe 14. MOTHER'S MAIDEN NAME Hilda Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES? no 16. SOCIAL SECURITY NO. 216-38-8172 17. INFORMANT Richard L. Ratcliffe, Williamstonburg, Md.

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Tracheal Cancer Spine  
DUE TO Multiple Metastases  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Aspiration

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II if item 18) Auto struck tree - Route # 2

20c. TIME OF INJURY Month, Day, Year 4:10 P.M. 5-7 1961 20d. INJURY OCCURRED While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 2 20f. City or town A.R.C. (County) M.D. (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE E. L. N. Hart EXAMINER'S NAME (Type) E. L. N. Hart CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 5-7-61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5-10-61 22c. NAME OF CEMETERY OR CREMATORY Telghman Cemetery 22d. LOCATION (City, town, or country) Telghman, Md.

23. FUNERAL DIRECTOR Hamberton Harrison ADDRESS St Michael's 24a. REC'D BY REG. STRAR MAY 10 '61 24b. REGISTRAR'S SIGNATURE C. L. S. H. H.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

5152

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05142

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND  
b. CITY OR TOWN, if outside corporate limits write RURAL and give nearest town, Annapolis  
c. LENGTH OF STAY IN CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town, Annapolis  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived if institution, R-1, etc. or institution)  
a. STATE Maryland b. COUNTY Anne Arundel  
c. STREET ADDRESS 6 Washington St. Annapolis  
d. RESIDENCE ON FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last Hester PETTIT ROBINSON  
4. DATE OF DEATH May 8 1961  
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH Oct-18-1881 79 yrs.  
9. AGE (In years IF UNDER 1 YEAR, IN MONTHS, DAYS, HOURS, MIN.)  
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE New York 12. CITIZENSHIP U.S.  
13. FATHER'S NAME Theodore Pettit 14. MOTHER'S MAIDEN NAME Hester Keyser  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. Hester Q. Waer 17. INFORMANT Address (2)  
18. CAUSE OF DEATH (If only one cause, write only one; if more than one, write all)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis  
DUE TO (b)   
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)   
PART II. OTHER SIGNIFICANT CONDITIONS (a) Diabetes Mellitus, Arteriosclerotic Ht. Disease of Colon (b) Cancer of Colon  
20a. ACIDENT WAS UNKNOWN OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (If injury in Part I or Part II, item 18)  
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)  
21. I certify that I (Doctor or other) after I have viewed the body, on May 8, 1961, at 8:35 P.M., saw the deceased alive on May 8, 1961, and that death occurred at 8:35 P.M. from the causes and on the date stated above.  
22a. SIGNATURE (Signature of Edward S. Beck) M.D. 22b. DATE SIGNED 5/9/61  
22c. PHYSICIAN'S NAME (Type) Edward S. Beck 22d. ADDRESS 71 Franklin St., Annapolis, Md.  
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF May 10-1961 23c. NAME OF CEMETERY OR CREMATORY The Green Wood Cemetery 23d. LOCATION (City, town, county, State) Brooklyn N. Y.  
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor, Sr. Annapolis Md. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE MAY 10 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5153 CERTIFICATE OF DEATH 05143											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) • STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY in lb <u>3 years 6 mos. 22 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>				e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mae</u> Middle <u>Bell</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>1961</u>							
5. SEX <u>Female</u>				6. COLOR OR RACE <u>Negro</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>1909</u>				9. AGE (In years last birthday) <u>51</u> yrs				IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u> Hours <u>19</u> Min. <u>61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>1122.1</u> DUE TO (c) <u>Psychosis Associated with Cerebral Arteriosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION G. EN IN PART 1 <u>Psychosis Associated with Cerebral Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH							
20a. AL DEPT WAS CONTRIBUTING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>1122.1</u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1. Part 2 of 1 - - - - -) <u>1122.1</u>							
20c. TIME OF INJURY Month <u>5</u> Day <u>27</u> Year <u>1961</u> Hour <u>11</u> a.m. <u>57</u> p.m.				20d. INJURY OCCURRED Where <u>at work</u> <input type="checkbox"/> Not where <u>at work</u> <input type="checkbox"/>				20f. City or town <u>Crownsville</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> to <u>5/27</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>5/27</u> , 19 <u>61</u> and that death occurred <u>6:40</u> M, from the causes and on the date stated above.				22a. SIGNATURE <u>L. Benedict, M.D.</u>				22b. DATE SIGNED <u>5/29/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>				22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/27/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24b. ADDRESS <u>[Address]</u>				25a. REC'D BY REG. STRAR <u>[Signature]</u>			
				25b. REGISTRAR SIGNATURE <u>[Signature]</u>				DATE <u>MAY 30 '61</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5154

05144

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND  
b. CITY OR TOWN Annapolis c. LENGTH OF STAY IN 1b 3 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if not full-time residence, give address on)  
a. STATE Maryland b. COUNTY Anne Arundel  
c. CITY OR TOWN Annapolis d. STREET ADDRESS 111 Severn Ave.,  
4. DATE OF DEATH May 21 1961

3. NAME OF DECEASED (Type or print) Catherine Anne SCHENCK  
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH May 18, 1961  
9. AGE (in years last birthday) 2 yrs. 17 months 17 days 5 hours 3 min.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 10b. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (County & State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Robert Edwin SCHENCK 14. MOTHER'S MAIDEN NAME Resanne Catherine DuPLESSIS  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. \_\_\_\_\_ 17. INFORMANT Hospital records. Address \_\_\_\_\_

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pneumonia  
DUE TO (b) \_\_\_\_\_  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) \_\_\_\_\_  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (c) \_\_\_\_\_

19. INTERVAL BETWEEN ONSET AND DEATH 2 days

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year May 18, 1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 20f. (City or town) Annapolis (County) Anne Arundel (State) Md.

21. I certify that (I) Stuart M. Walker attended the deceased from May 18, 1961 to May 20, 1961, that (I) XXX last saw the deceased alive on May 20, 1961, and that death occurred at 3:30 A.M. from the causes and on the date stated above.  
22a. SIGNATURE Stuart M. Walker M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 5/23/61  
22c. PHYSICIAN'S NAME (Type) Stuart M. Walker 22d. ADDRESS 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, 23b. DATE THEREOF Burial 5/22/1961 23c. NAME OF CEMETERY OR CREMATORY St. Mary's 23d. LOCATION (City, town or county) Annapolis (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons Annapolis, Md. ADDRESS \_\_\_\_\_ 25a. REC'D BY REGISTRAR \_\_\_\_\_ 25b. REGISTRAR'S SIGNATURE Caroline E. Frazier DATE MAY 25 '61

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

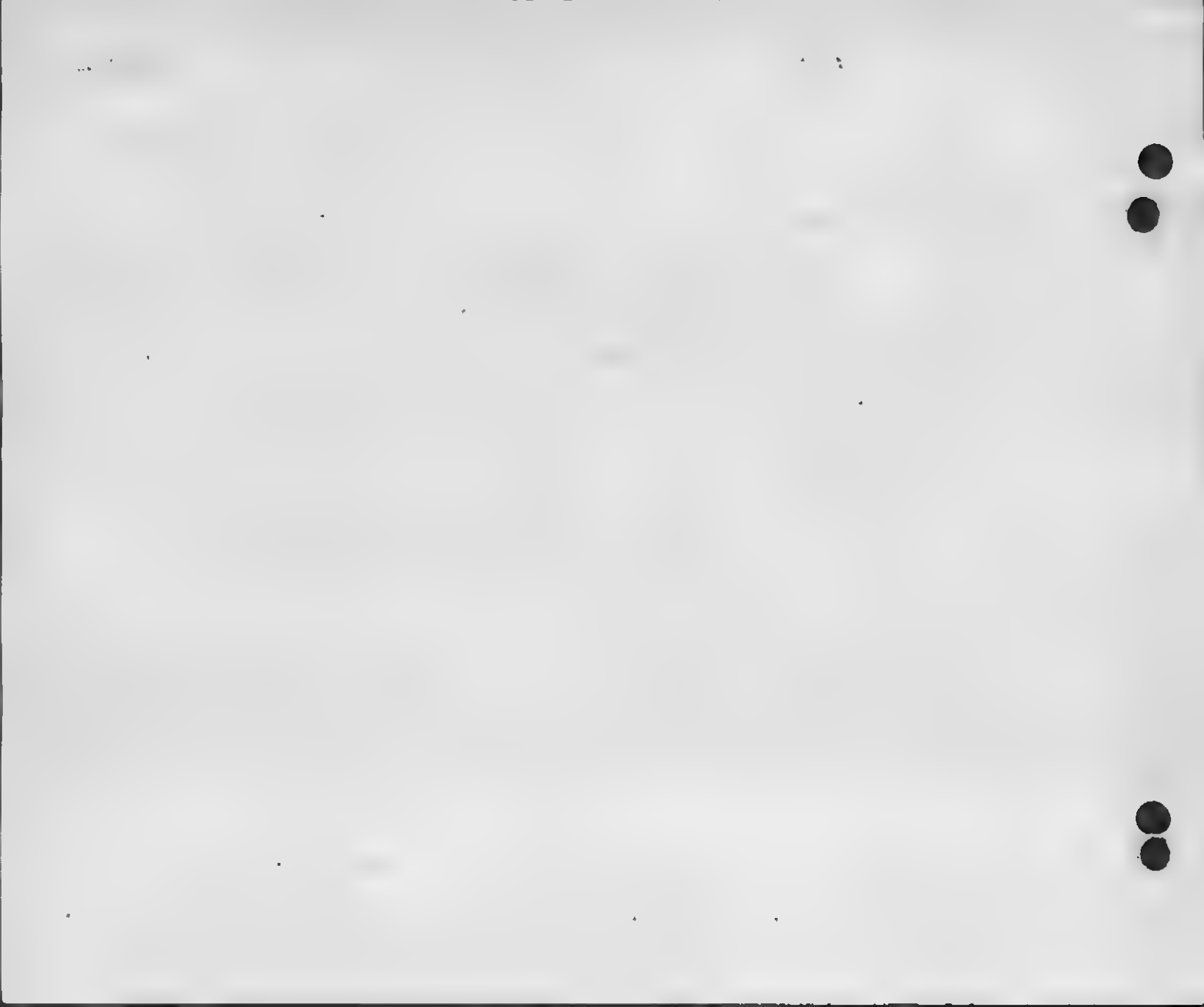
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5155

## CERTIFICATE OF DEATH

05145

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Record of Institution) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>121 Conduit St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Virginia SEARS</b>		4. DATE OF DEATH Month Day Year <b>May 4 1961</b>	
5. SEX <b>Female</b>		6. CO. OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Month Day Year <b>May 10, 1891</b>		9. AGE (In yrs. If under 1 year If 1 year or over) Last birthday Months Days Hrs Mins <b>69 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
13. FATHER'S NAME <b>James R. Sears</b>		14. MOTHER'S MAIDEN NAME <b>Resie Trott</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year and service) <b>No</b>		16. SOCIAL SECURITY NO. <b>6-----</b>	
17. INFORMANT <b>Jesse Sears</b>		18. ADDRESS <b>617 Hamlin St NE Washington, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If not related to terminal disease condition given in Part I) <b>Coronary Artery Disease</b>			
19. INTERVAL BETWEEN ONSET AND DEATH <b>11:45 P.M.</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter not less than 100 words. Part I, Part II of form) <b>Myocardial Infarction</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>May 4, 1961 11:45 P.M.</b>		20d. INJURY CLASSIFIED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21. I certify that I (Doctor) attended the deceased from <b>March 1958</b> to <b>May 4, 1961</b> and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above.		22. SIGNATURE <b>Emily H. Wilson, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 7, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		23d. LOCATION <b>Anne Arundel Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons</b>		25. REC'D BY REGISTRAR <b>MAY 9 '61</b>	
26. REGISTRAR'S SIGNATURE <b>Ann Arundel</b>		27. REGISTRAR'S SIGNATURE <b>Ann Arundel</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5156

05146

1. PLACE OF DEATH  
a. COUNTY

Anne Arundel

MARYLAND

2. USUAL RESIDENCE (Where dec. used lived. If institution, R. or I. or other institution, State and County)

a. STATE Maryland

b. COUNTY Anne Arundel

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

10 days

c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

RURAL - Harwood

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Anne Arundel General Hospital

d. STREET ADDRESS

IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

3. NAME OF DECEASED  
(Type or print)

Eleanor

SHEPHERD

4. DATE OF DEATH

Month May

Day 16

Year 1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Sept. 27, 1880

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 12 HRS

80 yrs.

Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE County & State or foreign country

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

C. PERCIVAL CHESTNUT

14. MOTHER'S MAIDEN NAME

Sally C. Arundel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Wm. Shepherd, Harwood Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Myocardial infarction

DUE TO

18a. WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last

Diabetes mellitus + arteriosclerosis

DUE TO

hypertensive pneumonia

PART II. OTHER SIGNIFICANT CONDITIONS (ONLY IF NOT THE CAUSE OF DEATH BUT NOT RELATED TO THE TERMINAL DISEASE) (CONDITION GIVEN IN PART I)

INTERVAL BETWEEN ONSET AND DEATH

WAS A POSTMORTEM PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. Enter a brief description of injury in Part I, Part II, or III

20c. TIME OF INJURY Month, Day Year  
Hour a.m. p.m.

20d. INJURY OCCURRED  
When at work ☐ Not when at work ☐

20e. PLACE OF INJURY Home farm factory, street office bldg., etc.

20f. City or town (County) (State)

21. I certify that (I) ~~was~~ attended the deceased from

April, 1950 to May 15, 1961

saw the deceased alive on May 15, 1961 and that death occurred at M. from the causes and on the date stated above.

22a. SIGNATURE

Emily H. Wilson

ATTENDING PHYS.

MD

22b. ADDRESS

STAFF PHYS.

Lothian, Md.

23a. BURIAL, CREMATION, or other disposal of body

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

1-10

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE MAY 29 '61

Arthur S. Hume

TO HO: R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HC  
death  
VR A15 (4)  
ISM 9/60

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

5157

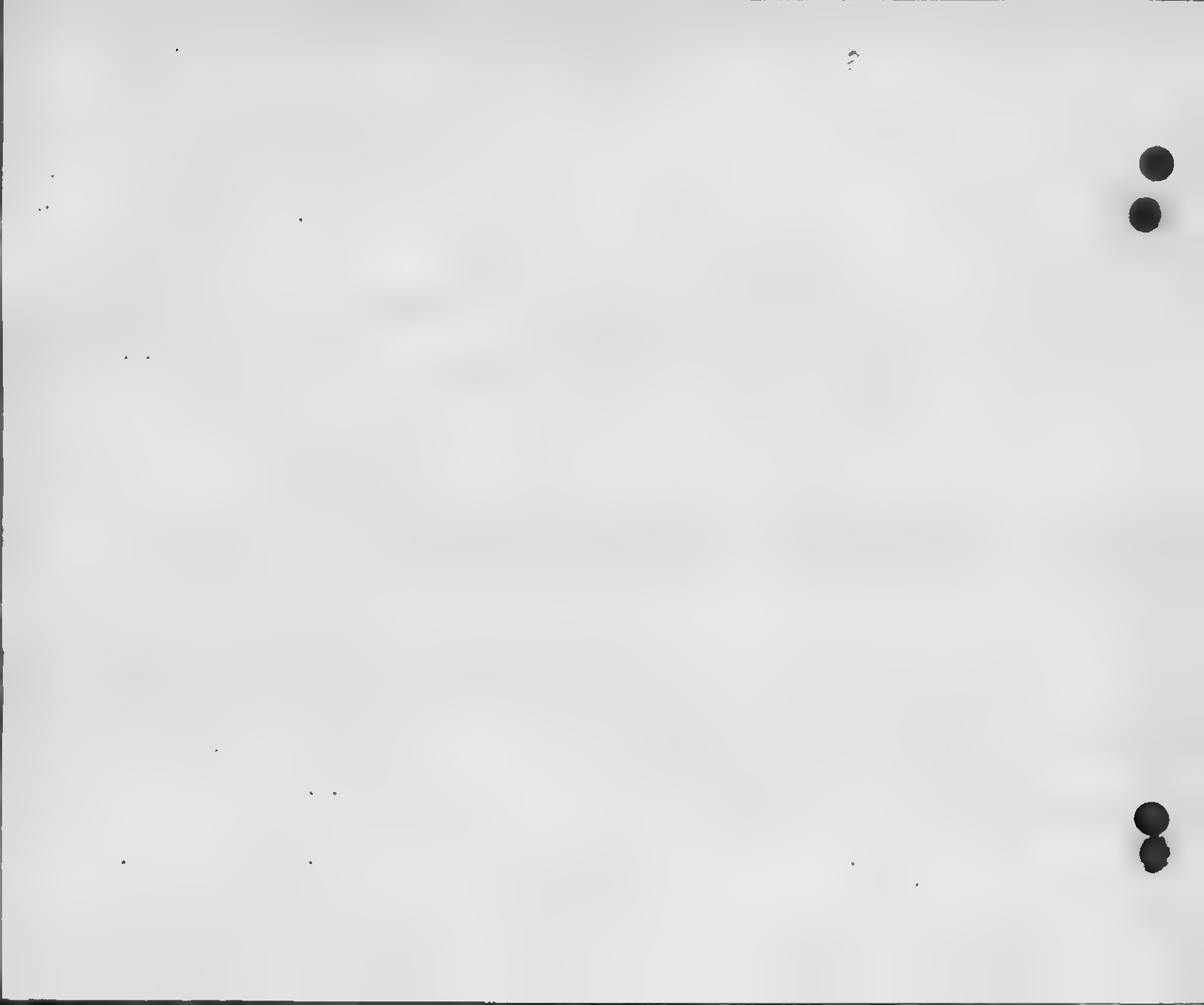
05147

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution)  
a. STATE Maryland b. COUNTY Anne Arundel  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis  
d. STREET ADDRESS 11 Ridout St.

3. NAME OF DECEASED (Type or print) John First Simms Middle Last  
4. DATE OF DEATH May 17 1961 Month Day Year  
5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH May 10, 1869 9. AGE (In years last birthday) 92 yrs. 10. IF UNDER 1 YEAR ☐ Months Days 11. IF UNDER 24 HRS. ☐ Hours Min.  
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired Retired  
10b. KIND OF BUSINESS OR INDUSTRY None  
11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.  
13. FATHER'S NAME William Simms 14. MOTHER'S MAIDEN NAME Elizabeth Harrison  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ☐ 16. SOCIAL SECURITY NO. None 17. INFORMANT James Simms Address 117  
18. CAUSE OF DEATH (Enter only one cause per line, but do not omit terminal condition given in Part I)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Stroke DUE TO Arteriosclerosis  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last None DUE TO None  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISORDER GIVEN IN PART I None  
19. a. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)  
20c. TIME OF INJURY Hour am pm 20d. INJURY OCCURRED At work 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home 20f. City or town Annapolis County Anne Arundel State Md.  
21. I certify that (1) James Simms attended the deceased from May 17, 1961 to May 17, 1961 that (1) James Simms saw the deceased alive on May 17, 1961 and that death occurred at 7:45 A.M. from the causes and on the date stated above.  
22a. SIGNATURE A. T. Allen 22b. DATE SIGNED May 19 '61  
22c. PHYSICIAN'S NAME (Type) A. T. Allen 22d. ADDRESS 62 Cathedral St., Annapolis, Md.  
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial 23b. DATE THEREOF 5-20-61 23c. NAME OF CEMETERY OR CREMATORY Burial 23d. LOCATION (City, town or county) Annapolis, Md.  
24. FUNERAL DIRECTOR'S SIGNATURE William Simms ADDRESS 117 25a. REC'D BY REGISTRAR May 19 '61 25b. REGISTRAR'S SIGNATURE William Simms



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5158

05148

1. NAME OF DECEASED  
(Type or Print)

EZRA Lee Smarr

2. DATE OF DEATH

5-3-61

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

4914 Brookwood Rd

4. USUAL RESIDENCE (Where deceased lived If institution residence before admission)

a. STATE

b. COUNTY

MD

AA County

c. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Balto

d. STREET ADDRESS

(If rural, give location)

4914 Brookwood Rd

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 11, 1895

9. AGE (In years  
lost birthday)

65

If Under 1 Year

Months

Days

Hours

Min

10. A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even  
if retired)

Retired

10. B. KIND OF BUSINESS OR INDUSTRY

Gov. worker

11. BIRTHPLACE (State or foreign country)

W. Va

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

UNK

14. MOTHER'S MAIDEN NAME

UNK

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown)

NO

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO

17. INFORMANT

Family

ADDRESS

Same

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A) DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

2 yrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐

22. I certify that (I) (this hospital) attended the deceased from

May 30, 1961

that (I) last saw the deceased alive on

May 30, 1961

and that in (my) opinion death occurred at 1:50 am. from the causes and on the date stated above.

23a. SIGNATURE

Attending Phys ☒

Med Director ☐

Staff Phys ☐

M D

23b. ADDRESS

520 Ritchie Hwy - 25.

23c. DATE SIGNED

May 31, 1961

24a. BURIAL, CREMATION,  
REMOVAL (Specify)

B

24b. DATE

6-2-61

24c. NAME OF CEMETERY OR CREMATORY

Super Creek Cem.

24d. LOCATION

(City, town, or county)

Baltimore, W. Va

(State)

25a. DATE REC'D BY HEALTH DEPT.

JUN 1 '61

25b. NAME OF REGISTRAR

Harriet S. Brown

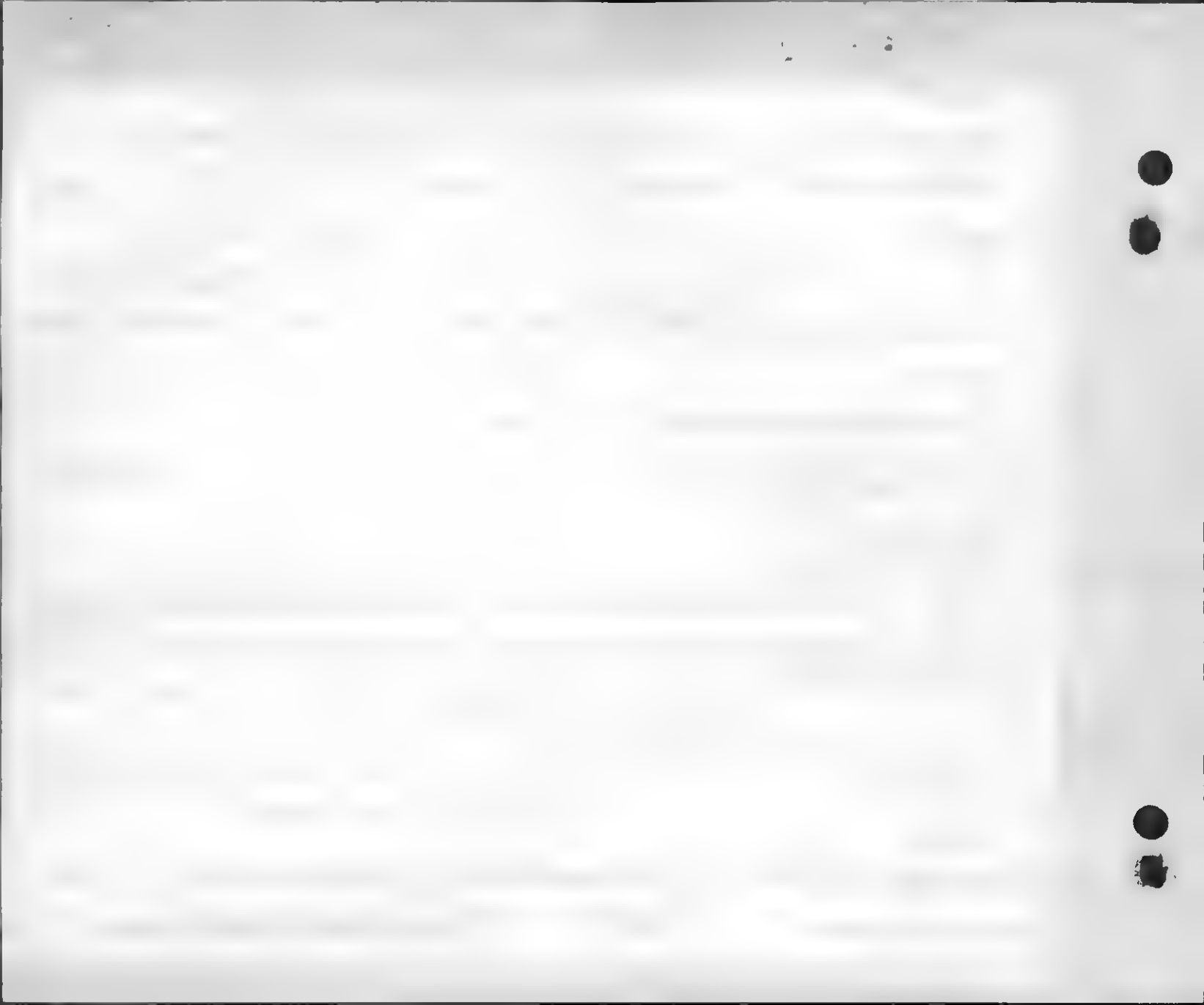
25c. FUNERAL DIRECTOR

McCullh Funeral Home 120 E. Ave

ADDRESS

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/61





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

05149

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARVEL BEACH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARVEL BEACH</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>320 CARVEL BEACH ROAD</u>		d. STREET ADDRESS <u>320 CARVEL BEACH ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>LLOYD</u> Middle <u>WILLIAM</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>26</u> Year <u>1961</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>DEC 18, 1914</u>
9. AGE (in years last birthday) <u>46</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>	11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		12 CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13 FATHER'S NAME <u>RICHARD TAYLOR SMITH</u>		14 MOTHER'S MAIDEN NAME <u>MARY POLZIN</u>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give war or date of service) <u>YES</u> <u>11/19/43-6/1/45</u>		16 SOCIAL SECURITY NO. <u>214 018965</u>	
17 INFORMANT <u>THELMA SMITH</u>		Address <u>SAME</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>CORONARY SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 years</u> <u>16 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I attended the deceased from <u>MARCH 3</u> , 19 <u>61</u> , to <u>MAY 26</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>MAY 20</u> , 19 <u>61</u> , and that death occurred at <u>4:50 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u>		ADDRESS (Street, city or town, state) <u>3471 FT. SMALLWOOD ROAD</u>	
PHYSICIAN'S NAME (Type) <u>J BRADY SMITH</u>		DATE SIGNED <u>5/26/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-29-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE J. CONCE</u>		ADDRESS <u>4001 RITCHIE HWY.</u>	
24a. REC'D BY REGISTRAR <u>MAY 31 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5160

05150

### 1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF DECEASED (Type or print)

Margaret

May

5. SEX

Female

White

WIDOWED ☒

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

own home

13. FATHER'S NAME

Unknown

### 2. USUAL RESIDENCE (Where deceased lived. If institution, R. state, S. state, or on)

a. STATE

Maryland

b. COUNTY

Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

d. STREET ADDRESS

Green Briar Lane

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

4. DATE OF DEATH

Month

Day

Year

May

29

1961

8. DATE OF BIRTH

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

Feb. 28, 1884

77 yrs.

Months Days Hours Min.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

Kentucky

U.S.

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

CEREBRAL THROMBOSIS

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

ARTERIOSCLEROSIS, GENERALIZED

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION SET FORTH IN PART I.

INTERVAL BETWEEN ONSET AND DEATH

17 DAYS

Unknown

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

State

21. I certify that (I) ~~physician~~ attended the deceased from May 12, 1961, to May 29, 1961, that (I) ~~last~~ saw the deceased alive on May 29, 1961, and that death occurred at 3:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Edward S. Beck

M.D.

ATTENDING PHYS

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

22d. ADDRESS

71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

BURIAL-REMOVAL

May 30, 61 Bellevue Memorial Cmet.

Daytona Beach, Fla.

24. FUNERAL DIRECTOR'S SIGNATURE

24b. ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

HOPPING FURNACE HOME

Annapolis, Maryland

DATE

JUN 1 '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5161

05151

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution) a. STATE <b>Maryland</b> b. COUNTY <b>South-Carolina</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>17 mos. 22 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>2307 Orem Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Orabell</b>		4. DATE OF DEATH Month <b>5</b> Day <b>23</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 8, 1909</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>South Carolina</b>	
13. FATHER'S NAME <b>Clay Coleman</b>		14. MOTHER'S MAIDEN NAME <b>Isabella Burnside</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-30-8433</b>	
18. CAUSE OF DEATH (Enter only one cause; if line for b and c, give rise to immediate cause (a), stating the underlying cause last.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Decubitus Debilitated Condition</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Decubitus Debilitated Condition</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10/1</b> p.m. <b>5/23</b>		20d. INJURY OCCURRED Where <b>at work</b> <input type="checkbox"/> <b>at work</b> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>Baltimore</b>	
20g. (County) <b>-----</b>		20h. (State) <b>Maryland</b>	
21. I certify that (I) (if hospital) attended the deceased from <b>10/1</b> to <b>5/23</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5/23</b> , 19 <b>61</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. Benedict, M.D.</b>		22b. DATE <b>5/24/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23b. DATE THEREOF <b>5-27-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	
23d. LOCATION (City, town or county) <b>Baltimore, Maryland</b>		23e. REGISTRAR'S SIGNATURE <b>-----</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>-----</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 25 '61</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



may be signed by the attending physician or attending physician, or by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5162

05152

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>				d. STREET ADDRESS <u>1100 N. E. St.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Thomas</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-1904</u>		9. AGE (In years last birthday) <u>56</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>19</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Smith</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>1-234-56789</u>		17. INFORMANT <u>Walter H. Smith</u>		Address <u>1100 N. E. St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO (b) <u>Chronic Obstructive Bronchitis</u> DUE TO (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>1-2</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>12</u> Day <u>19</u> Year <u>1961</u> Hour <u>11</u> a.m. <u>10</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>Md</u>	
21. I certify that (i) (this hospital) attended the deceased from <u>11-10</u> 19 <u>58</u> to <u>April 11</u> 19 <u>61</u> that (i) (we) last saw the deceased alive on <u>4-25</u> 19 <u>61</u> and that death occurred at <u>8:45</u> A.M. from the causes and on the date stated above							
22a. SIGNATURE <u>D. K. McDonald</u>				22b. DATE SIGNED <u>11/16</u>			
22c. PHYSICIAN'S NAME (Type) <u>D. K. McDonald</u>				22d. ADDRESS <u>1100 N. E. St.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-19-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d. LOCATION (City, town, or county, State) <u>Baltimore, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. [Signature]</u>				25a. REC'D BY REGISTRAR. 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
DATE <u>May 10 61</u>				TIME <u>10:00</u>			

M

I

MEDICAL CERTIFICATION





5163

MEDICAL CERTIFICATION

TO HC  
death  
TO FUJ  
director  
be file  
VR A15 (4)  
15M 9/60

Mr. J. H. ...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5164

05154

1. PLACE OF DEATH  
a. COUNTY **MARYLAND**  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **ANNE ARUNDEL**  
c. LENGTH OF STAY IN 1b **34 DAYS**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **ANNAPOLIS**  
2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)  
a. STATE **MARYLAND**  
b. COUNTY **ANNE ARUNDEL**  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **ANNAPOLIS**  
d. STREET ADDRESS **16 Spa View Avenue**  
3. NAME OF DECEASED (Type or print) **William Winfield VANOUS**  
4. DATE OF DEATH **May 14 1961**  
5. SEX **Male**  
6. COLOR OR RACE **Cauc.**  
7. MARRIED ☒ NEVER MARRIED ☐  
8. DATE OF BIRTH **23 April 1909**  
9. AGE (In years last birthday) **52** yrs.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Naval Officer**  
10b. KIND OF BUSINESS OR INDUSTRY **Maryland**  
11. BIRTHPLACE (County & State, or foreign country) **United States**  
12. CITIZEN OF WHAT COUNTRY? **United States**

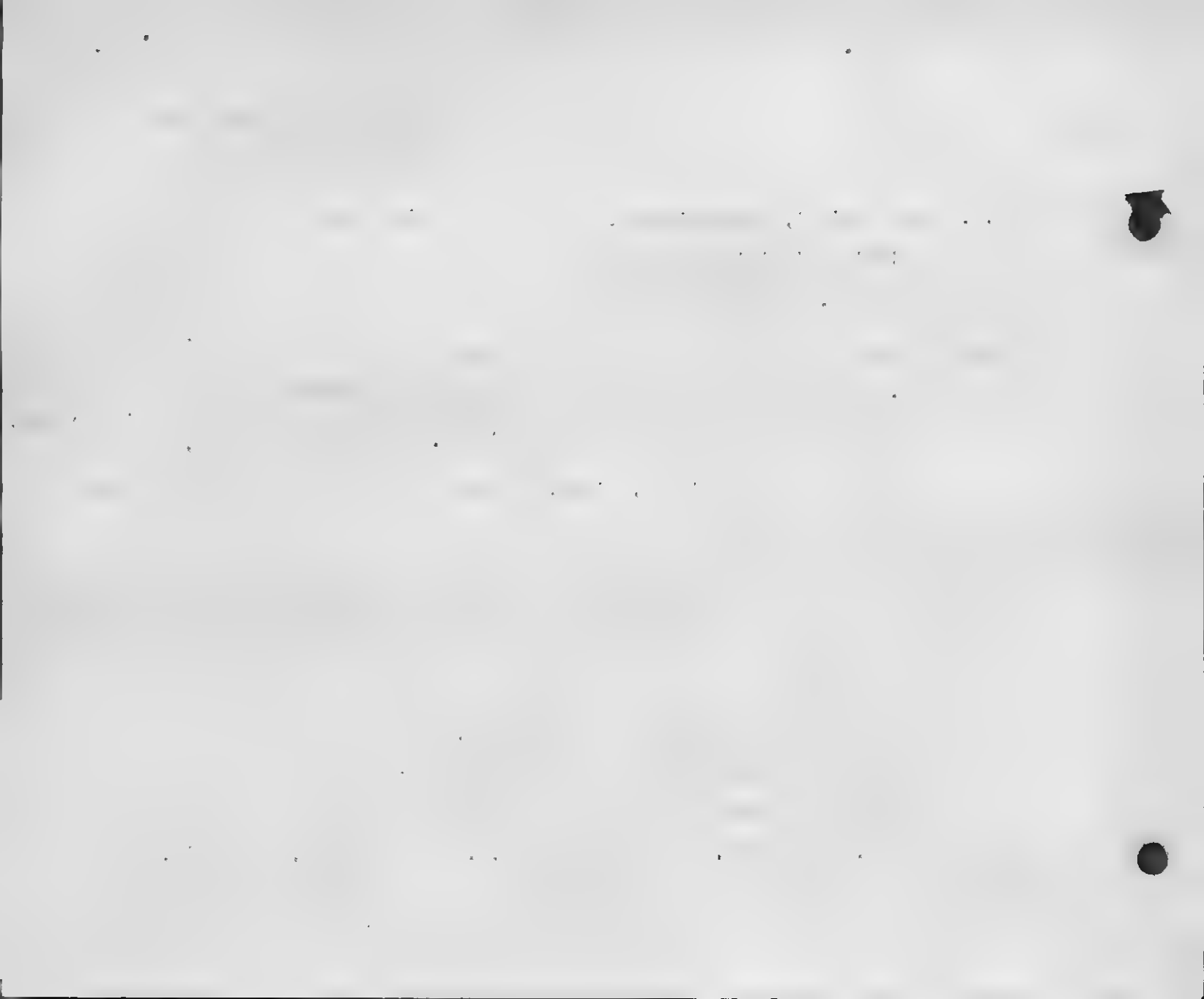
13. FATHER'S NAME **William J. VANOUS**  
14. MOTHER'S MAIDEN NAME **Daisy Elizabeth SMITH**  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes**  
16. SOCIAL SECURITY NO. **WW 11**  
17. INFORMANT **Katherine B. VANOUS**  
Address **16 Spa View Avenue, Annapolis, Maryland**  
INTERVAL BETWEEN ONSET AND DEATH **72 Weeks**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **CARCINOMA, Liver, Widespread**  
126-1 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐  
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)  
20c. TIME OF INJURY Month, Day, Year **19**  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

21. I certify that (i) (this hospital) attended the deceased from **10 April 1961** to **14 May 1961** that (I) (we) last saw the deceased alive on **14 May 1961** and that death occurred at **3:25p** from the causes and on the date stated above  
22a. SIGNATURE **N. (n) ZOURAS**  
22b. DATE SIGNED  
22c. PHYSICIAN'S NAME (Type) **N. (n) ZOURAS, LT MC USNR**  
22d. ADDRESS **U.S. Naval Hospital, Annapolis, Maryland**

23a. BURIAL, CREMATION **BURIAL**  
23b. DATE THEREOF **5-17-61**  
23c. NAME OF CEMETERY OR CREMATORY **U.S. NAVAL ACADEMY**  
23d. LOCATION (City, town or county) (State) **ANNAPOLIS MD.**  
24. FUNERAL DIRECTOR'S SIGNATURE **JOHN M. TAYLOR, SON**  
ADDRESS **ANNAPOLIS MD.**  
25a. REC'D BY REGISTRAR **MAY 17 '61**  
25b. REGISTRAR'S SIGNATURE **Charles S. Hume**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician for 4 days after the death. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH  
a. COUNTY **Anne Arundel**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Annapolis**  
c. LENGTH OF STAY IN **MARYLAND**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Anne Arundel General Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before death)  
a. STATE **Maryland**  
b. COUNTY **Anne Arundel**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **RURAL - Severn**  
d. STREET ADDRESS **Old Oak Road**

3. NAME OF DECEASED (Type or print)  
First **Patsy** Middle **(Pasquale)** Last **VARIALI**  
4. DATE OF DEATH  
Month **May** Day **29** Year **1961**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ DATE OF BIRTH **May 17, 1895**  
8. AGE in years at birth **66** yrs. 9. AGE in years if **66** yrs. 10. IND OF BUSINESS OR INDUSTRY **Storekeeper (ret.) Self Emp.**  
11. PLACE OF BIRTH **Italy** 12. COUNTRY OF BIRTH **U.S.A.**

13. MOTHER'S NAME **Louise (unknown)**

14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **no**

15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Cerebral Hemorrhage**  
DUE TO **Hypertension**  
Conditions, if any, which gave rise to immediate cause (b) **10 hours**  
(c) **10 years**

16. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. **10 years**

17. WAS AN AUTOPSY PERFORMED? (Yes ☐ No ☒)

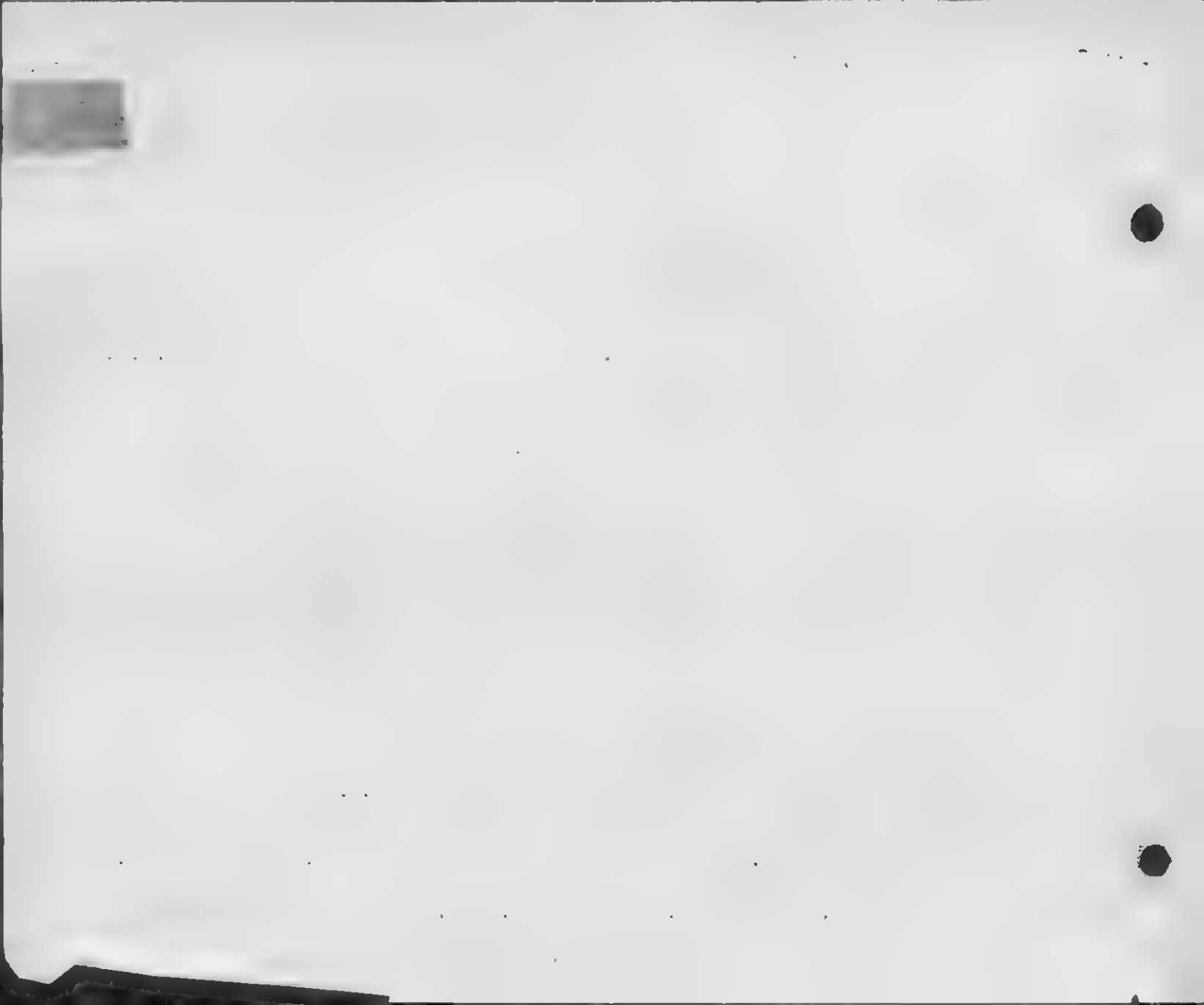
18. A. DECEASED WAS UNDERLYING OR CONTINUING ILLNESS OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20a. TIME OF INJURY  
Hour a.m. **7:40 A.M.** p.m. **19**  
20b. DESCRIBE HOW INJURY OCCURRED, Ent. nature of injury in Part I or Part II of item 18.  
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **100 Cathedral St., Annapolis, Md.**

21. I certify that (1) **Richard I. Hochman** attended the deceased from **May 29, 1961** to **May 29, 1961** that (1) **no** last saw the deceased alive on **May 29, 1961** and that death occurred at **7:40 A.M.** from the causes and on the date stated above

22. SIGNATURE **Richard I. Hochman** M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ DATE **5/29/61**

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** 23b. DATE THEREOF **2nd June '61** 23c. NAME OF CEMETERY OR CREMATORY **St. Bernards Ch. Cem.** 23d. LOCATION (City, town or county) **Indiana, Pennsylvania**

24. FUNERAL DIRECTOR'S SIGNATURE **Richard I. Hochman** ADDRESS **Glenburnie, Maryland** 25. REC'D BY REGISTRAR **JUN 1 '61** 25b. REGISTRAR'S SIGNATURE **Arthur P. ...**



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05156

5166

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT GEORGE G MEADE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT GEORGE G MEADE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. ARMY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DOROTHY</b> Middle <b>MURTACH</b> Last <b>WHITE</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>31</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 May 1908</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Murtach</b>				14. MOTHER'S MAIDEN NAME <b>Alice Joder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Husband Lt Col Harry J White (Item d)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion and edema</b> <b>522X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-</b> DUE TO (c) <b>-</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>31 May</b> to <b>31 May</b> , that I examined <b>10:40 P</b> and that death occurred at <b>M</b> , from the causes and on the date stated above. drive on <b>XXXXXX</b> and that death occurred at <b>XXXXXX</b> ADDRESS (Street, city or town, state) <b>USA Hosp Ft Geo G. Meade, Md</b> DATE SIGNED <b>31 May 61</b>							
ACTUAL SIGNATURE <b>Sherman S. Robinson</b> M.D.				PHYSICIAN'S NAME (Type) <b>SHERMAN S. ROBINSON, CAPT., M.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5 June 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rinaldi Funeral Home Inc</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 5 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Parnas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5167

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold

c. LENGTH OF STAY IN 1b X

d. NAME OF HOSPITAL (If not in hospital, give street address) Paradise Hill Farm

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Maryland b. COUNTY Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold

3. NAME OF DECEASED (Type or print) HENRY First A. Middle WRIGHT Last

4. DATE OF DEATH Month May Day 14 Year 1961

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH JAN. 31, 1904 9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR: Months 5 Days 14 Hours 14 Min. 1961

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive

10b. KIND OF BUSINESS OR INDUSTRY Farm Implement

11. BIRTHPLACE (State or foreign country) Louisiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Willis M. Wright

14. MOTHER'S MAIDEN NAME Sarah Co Hrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT Martha G. Wright Address ②

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) HEPATIC FAILURE  
DUE TO 157X  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) METASTATIC ADENOCARCINOMA  
DUE TO CARCINOMA OF HEAD OF PANCREAS (c)

INTERVAL BETWEEN ONSET AND DEATH 2 WKS  
MORE THAN 3 MOS  
UNDETERMINED

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-3 1961, to 5-14 1961, that (I) (we) last saw the deceased alive on 5-4 1961, and that death occurred at 3:30 AM, from the causes and on the date stated above.

22a. SIGNATURE Barber C. Palmer Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 5-15-61

22c. PHYSICIAN'S NAME (Type) Barber C. Palmer, Jr., M.D. 22d. ADDRESS 77 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF 5-15-61 23c. NAME OF CEMETERY OR CREMATORY A. Lincoln 23d. LOCATION (City, town, or county) (State) Bladensburg Md.

24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons ADDRESS Annapolis, Md. 25a. REGISTERED BY REGISTRAR — DATE 5-17-61 25b. REGISTRAR'S SIGNATURE —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

